ANNUAL REPORT

2018 – 2019

MANSFIELD
DISTRICT HOSPITAL

Disclosure Index

The annual report of the Mansfield District Hospital is prepared in accordance with all relevant Victorian legislation.
This index has been prepared to facilitate identification of the Department's compliance with statutory disclosure requirements.

Manner in which the Health Service was established

Mansfield District Hospital was established and incorporated in 1876 to provide health services to the Mansfield district.

Responsible Ministers

The Honourable Jill Hennessy, Minister for Minister for Health and Minister for Ambulance Services	01/07/2018 – 29/11/2018
The Honourable Jenny Mikakos, Minister for Health and Minister for Ambulance Services	29/11/2018 – 30/06/2019
The Honourable Martin Foley, Minister for Housing, Disability and Ageing	01/07/2018 – 29/11/2018
The Honourable Martin Foley, Minister for Minister for Health	01/07/2018 – 30/06/2019
The Honourable Luke Donnellan, Minister for Child Protection, Minister for Disability, Ageing and Carers	29/11/2018 – 30/06/2019

Objectives, Functions, Powers and Duties

The objectives of the Health Service are to:

1. Operate a public hospital in accordance with the Act, and any enabling Commonwealth or Victorian legislation, including the provision of the following services:
    a. Public hospital services;
    b. Primary health services;
    c. Aged care services; and
    d. Community health services.
2. Provide a range of health and related services ancillary to those services described in clause 1;
3. Carry on any other activity or business that is convenient to carry on in connection with providing the services described in clauses 1 and 2, or which are intended or calculated to make any of the Health Service's assets or activities more efficient and effective.

Vision, Mission and Values

Our Vision

To be a leader in integrated health care.

Our Mission

To provide consistent quality health services to the community of Mansfield and district that reflect best clinical practice, are cost effective and responsive to community need.

Year in review

Governance

The clear focus over the past twelve months has been on delivering a high quality and safe health service to the Mansfield District, the community that we serve and who in turn rely on their hospital to be there when needed. While MDH is classified as a small rural hospital our remote location requires that we deliver excellence across a broad and diverse range of health services.

During the year we continued to develop Board Director skills in key areas including safety and quality, consumer engagement and finance.

The past twelve months has been a period of renewal for the Board of Directors as we farewelled two retiring Directors and welcomed three new Directors to the Board.

We thank our retiring Board Directors Laurie Watters and Karli Brkljacic for their contribution and service to MDH and wish them well in their new endeavours.

In July 2019 we welcomed three new Board Directors who have added further to the diversity and the skill mix of the Board.

Dr Louis Irving is an accomplished clinician having worked in public hospitals for over 40 years. Louis has a strong interest in quality, safety and teamwork in healthcare.

Lisa Morgan is an experienced CPA qualified accountant who has a particular interest in Financial Management and Accounting, Audit and Risk Management and ICT Strategy and Governance.

Jeremy Madin re-joins the MDH Board after a brief absence. We welcome his breadth of skill and experience in particular in relation to the key areas of Governance, Strategic Leadership and Risk Management.

The past year has been a particularly busy year for the Board and the Executive as we continue to address key issues that confront our health service in an ever changing and challenging environment and against a backdrop of shifting demographics, advances in technology and the imperative of meeting community needs. I thank all members of our Board of Directors for their selfless contribution during the year as we strive to provide a safe, high quality and caring health service to our community.

Safety and Quality

As a small rural hospital in a remote area of Victoria our key objective is the provision of a safe, high quality and consumer centric health service to our community. The changes made in 2017/2018 in response to the 2016 review of Hospital Safety and Quality Assurance in Victoria have been far reaching and continued to drive change over the past twelve months as we seek to be the best that we can be.

In July 2018 we embarked on a program to create a great quality system built around enhancing the consumer experience at the point of care. We called this program *Great Care @ MDH*. The groundwork undertaken in late 2018 which led to the development of the Great Consumer Experience Plan included engaging with staff and consumers, identifying the purpose, the people and the pillars of a great quality system. Having developed local consumer experience plans and linking the activities of the quality system to the activities of creating a great consumer experience, *Great Care @ MDH* was launched in April 2019.

Those who attended the 2018 Annual General Meeting were privileged to hear a patient story that was inspiring and provided insights into one young woman's journey in the face of adversity. This underscores why it is so important to base our model of care around enhancing the consumer experience at the point of care. Patient stories provide a moment of clarity and remind us all of what is important as we strive to deliver a consumer centric, safe and high quality health service.

The Safety and Quality Committee, Chaired by Dr Pamela Dalgliesh and ably supported by the Executive and staff has been instrumental in ensuring a strong linkage between strategic direction and operational effectiveness.

In regard to key performance benchmarks I am pleased to report that we again met or exceeded accreditation standards and implemented new initiatives, notably:

- National Safety & Quality Health Service (NSQHS) standards
- Aged Care Quality Standards
- Home Care Standards
- Proactive development of Occupational Health and Safety strategies with an emphasis on addressing Occupational Violence and Aggression
- Ongoing positive results in the Victorian Health Experience Survey and the People Matter Survey
- Continued focus on priority areas identified in the Aboriginal cultural competence audit and the cultural diversity framework
- Ongoing consumer representation on advisory groups or committees and a renewed focus on improving the consumer experience at point of care

In June 2019 we formally adopted The Charter for Inclusion ensuring that Mansfield District Hospital Board of Directors, Executive and staff are committed to the provision of health services that are inclusive to all whilst considering the diverse and individual needs of our community and staff irrespective of gender, sexuality, disability, race or religion. We are committed to ensuring all people have equal access to quality health care.

Our People

In my 2017/18 report I stressed that people are at the heart of everything we do and it is the people at MDH that makes our health service great! I would like to thank all our staff for their dedication and commitment they have shown and for so enthusiastically embracing our goals and objectives as we strive to provide the best care possible to our community in 2018/19.

In 2018/19 we continued to invest in our people at all levels of the organisation whether through on the job training or tailored external training courses. We value the contribution of all our staff and our aim is to assist each staff member to fulfil their potential.

Over the course of the year we expanded the range of education provided to staff both in house and externally. There has been a strong emphasis on maintaining clinical competency in obstetrics. We have increased the number of undergraduate student placements, particularly in allied health. We are proud of our ability to provide Gap year employment opportunities for local secondary students, postgraduate opportunities for newly qualified registered nurses and supported a staff member in obtaining qualifications as a midwife.

I would like to make special mention of the excellent leadership provided by our CEO, Cameron Butler. Cameron and his Executive team have worked tirelessly over the past year to provide a high quality and safe health service to our community in a challenging and constantly changing environment;

Without the strong leadership and inclusive management style of our CEO, Cameron Butler and the unwavering support of a dedicated and professional executive team we could not provide the range and quality of services that are vital to meeting the needs of our community. Our Executive are a well led and cohesive management team and I thank them for their superb effort over the past year and in particular the support that they have provided to the Board of Directors.

We are again indebted to our dedicated and professional Visiting Medical Officers without whom we could not provide the range or quality of services that are needed.

In November 2018, Dr John Elcock resigned as Director of Medical Services in order to assume increased responsibilities at Northeast Health Wangaratta. We thank John for his service and in particular for the wise counsel he provided to the Board, CEO and Executive. We extend a warm welcome to Dr Campbell Miller as our new Director of Medical Services.

In March 2019, we welcomed Urologist Dr Mark Forbes as a visiting specialist which has enabled an expansion of our theatre list to include Urology.

Finally, I would like to make special mention of the exceptional service of our retiring Chair of Audit and Risk Management Committee, Mr Jaya Naidu. Jaya led the Audit and Risk Management Committee with distinction for many years and was previously a MDH Board member for four years. On behalf of MDH and the broader community we most sincerely thank Jaya for his dedicated service and wish him well in his future retirement.

Our Community

We are a community hospital with a rich heritage of working together as a community to look after our own, so it was fitting that in February 2019 and as a result of a submission by the Mansfield Historical Society to the Commonwealth Grants Commission, a memorial seat to honour the service in WW1 of five Mansfield Nurses was dedicated. This seat is now located in a prominent position within the hospital grounds.

It is again appropriate that I acknowledge and thank the community that we serve for their unwavering support over the past year. That support is evident in the generosity of the community raising in excess of $158,000 through the annual appeal (including $51,000 donated by the Murphy family from their October Art Show).

To our hard working auxiliaries, the Mansfield District Hospital Auxiliary and the Bindaree Auxiliary, that have again been tireless in their support of our hospital I say thank you for your wonderful support.

I would like to specifically acknowledge the generous contribution by the Mansfield District Hospital Auxiliary in funding $125,000 for the purchase of theatre equipment required to enable the commencement of a Urology service in March 2019.

Often the support for our hospital extends well beyond the township of Mansfield as evidenced by the very generous contribution from Buller Ski Lifts who in September donated $100,000 to the Mansfield District Hospital Auxiliary from the auction sale of chairs from the decommissioned Blue Bullet Ski Lift.

We also continue to be well supported by other philanthropic groups, community organisations, the business community and traders of Mansfield and all those who reside in our community who get behind our hospital.

During the past year we were again well supported by The Harry and Clare Friday Foundation, A Third Hand, the Mansfield Freemasons Lodge, the Murphy family and all those who attended fundraising functions or events in support of MDH.

We offer our sincere thanks to all our support organisations and the volunteers who so generously give of their time and have contributed so much in 2018/19.

During the course of 2018/19 we continued to actively engage with the community as we involved consumer representatives on Board committees in particular the Safety and Quality, Community Advisory, and Audit and Risk Management committees. The links formed with the Mansfield Shire in past years are strengthening as we actively seek a wider and inclusive approach to the health and well-being of all Mansfield residents.

In the 2018 annual report I made mention of the launch of the Mansfield Restart program, a community led approach to address addiction and substance abuse in Mansfield and surrounding communities. I am pleased to report that to date this program has exceeded all our expectations. We have seen more than sixty people referred into the program, have provided education for secondary school students and facilitated training for medical officers.

As a publicly funded Small Rural Health Service we continue to work closely and collaborate with other health services within the Hume region, in particular Northeast Health Wangaratta. Once again we acknowledge and thank them for their support during the past twelve months. We also acknowledge the invaluable clinical and non-clinical support and advice provided by the Department of Health and Human Services.

Key Initiatives

Masterplan for MDH:

In 2018 we commenced the development of a Master Plan for MDH that will determine what infrastructure is needed now and in the future to deliver the services required by our community. Working in partnership with the Victorian Health and Human Services Building Authority the plan has identified various options for the future development of MDH and is now in the final stages of completion. The next stage will be to seek funding for the implementation of the preferred option.

Strategic Plan 2019 – 2024:

In April 2019 we briefed four specialist health sector consultancies in regard to the development of a Strategic Plan for MDH which will take us through to 2024. Cube Group consulting have been selected to work with the Board of Directors, the CEO and the executive to develop a plan that provides a strong foundation for the future. The process will be inclusive with staff and Visiting Medical Officers having the opportunity to contribute to the strategic planning direction through workshop consultations. The community and external stakeholders will also be consulted through a range of focus groups. This Strategic Plan will complement the work currently being undertaken to develop a Master Plan for the future development of MDH and the Clinical Services Plan completed in 2017.

Financial Performance

On our Hospital website you will find the following statement: "Provision of high quality care, meeting the needs of the community and operating in accordance with financial and non-financial performance targets are priorities". To quote my predecessor, "MDH is not a business offering health services, but a public health service that must be run on business-like lines. There is a big difference between those two models. For us it is people first, whether patients, residents or carers. We are mission driven, not profit focused."

We do however take seriously our responsibility to balance our budget and I am pleased to again report a sound financial performance for the budget year, culminating in a surplus. In a tight fiscal environment this is a very good outcome and I congratulate our CEO, the Executive and all our staff on achieving this result while also achieving challenging targets in relation to activity, safety and quality of service.

Acknowledgements

While we have specifically acknowledged the contributions of many within this report, we express our warmest thanks and gratitude to our community, Board of Directors, Executive team, Medical Officers, Staff and partner organisations.

Phillip Officer
Board Chair

Mansfield District Hospital Auxiliary Report

It was another successful year of fund raising for the Hospital Auxiliary. This financial year, our fund raising yielded $137,726.53 due to a number of successful functions and some very generous donations from Buller Ski Lifts, Rino and Diana Grollo and Rennie De Maria.

The Art Show in November was fantastic. It was the largest art exhibition we have ever undertaken. We hung 206 artworks. There was generally a very high standard of works and the major prizes were sponsored by Rotary, and the Harry and Clare Friday Foundation. D.P.G. Real Estate sponsored the People's Choice Award this year. The five highly commended prizes were sponsored by local businesses; Countrywide Automotive Repairs, Mansfield Fishing & Hunting, Mansfield Lotto Centre, Mansfield Floor Xtra, and Mansfield Motor Panel Repairs.

The Annual Golf Day was wonderful. The weather co-operated and the course was in fabulous condition. Local business, individuals and even some donors from out of Mansfield generously supported the event and we hope this continues for the foreseeable future. Mr. Craig Willis was our M.C. on the day and Mansfield FoodWorks donated the food for the lunch that was prepared by Auxiliary members and friends of the Auxiliary. Thanks go to Dion Theodossi who is our Major Sponsor and kindly provides a car for the Hole In One and to Chris Anderson and staff for providing the Golf Club and course for the day, and to Andy Luks who generously donated the restaurant facilities to us. Without the support of these generous and community minded people as well as many other supporters who provide goods and services for auctions, silent auctions and raffles, we could not hold this popular and successful event. Our thanks also goes to all those who worked tirelessly to run the event, Auxiliary members, friends of the Auxiliary and many others who helped on the day.

We hosted a movie evening in April showing Swimming With Men. A delightful light-hearted comedy that left everyone smiling.

Our last function for the year was a Canapé and Wine Pairing at Ros Ritchie's facility Magnolia House in early June. Gill Belle was the chef and Ros Ritchie the vigneron.

You must be asking yourselves what we have done with all these funds, and that's a fair question. We have been in a holding pattern for the better part of two years waiting for the Hospital to make changes to the infrastructure so that we can finalise the purchase – in conjunction with A Third Hand – of a new telemetry system for the wireless monitoring of cardiac and surgical patients. That initiative is moving forward, and we hope to sign off on it very shortly.

We also used the donation given to us by Buller Ski Lifts and Rino and Diana Grollo as well as some added monetary help from the Auxiliary to fund the new Urology Service that started in March 2019.

We have recently had two members of the Aux step down for various reasons – Di Burton, and Helen Clarke – both of whom will be missed, as they were dedicated workers for the Hospital Auxiliary. Fortunately, we have three new members to welcome to the Auxiliary – Sue Combes, Susie Harbison and Jenni McKenzie. We would like to see more new faces at our meetings, so please if you someone you know might be interested in joining the Auxiliary please ask them to call me or speak to an Auxiliary member.

Sue Swan
Auxiliary President

Bindaree Auxiliary Report

The Auxiliary is pleased to present this report of our activities over the past year. Membership while not large in number continues, with members committed to providing extras for the welfare and benefit of Bindaree residents. We continue to be encouraged by the contribution of some of the founder members of the Auxiliary, who have actively supported our activities for over forty years, and who are an example to us all. Members were saddened this year by the passing of one of our long time members Maureen Marshall, whose contributions were especially valued by the residents.

Stalls at the Bush Market, the Bonnie Doon Easter Market and FoodWorks produced support from different parts of the community, and provided an opportunity to publicise Bindaree Aged Care to the wider community. A very popular day was the Bridge and Card Day at Beolite Village. We are most grateful to Beolite for the use of their facilities and to local businesses for their support in kind. Fundraising also included the successful Fashion Parade with clothes modelled by members and the opportunity to purchase garments with the Auxiliary receiving commission on sales. A most successful raffle was drawn at the parade with major prizes donated by local businesses.

We have appreciated the professional services of Proactive Accounting.

The weekly visit of the shopping trolley (staffed by Auxiliary members on a rostered basis) is appreciated by the residents. The trolley enables us to have personal time with residents, and gives the residents an opportunity to purchase personal items and goods which they can share with family and friends. Residents look forward to this service and can give orders for particular items they may wish to purchase.

The Auxiliary liaises with the Activities team at Bindaree. The team is always involved in the provision of stimulating programs for the residents. This year we have been interested to watch the development of a program run in conjunction with the Men's Shed, where some of the residents were involved in making wooden toys and building bird feeders. The Auxiliary was very happy to fund materials for this project, and the obvious interest and enjoyment of those participating was good to see. We look forward to further opportunities to assist the Activities Team in this way. Other opportunities included the provision of a music program with large print word books and music CDs to assist with singalongs. Residents enjoyed singing old songs with which they were familiar. A music therapist was engaged to provide a ten week course of music and dance. At the request of residents, small tables were provided for use beside residents when having morning or afternoon tea.

Several Bindaree residents take advantage of the opportunity to go on outings in the bus provided by the Harry and Clare Friday Foundation. The Auxiliary has been pleased to fund some of these trips, and the morning or afternoon teas which are part of these outings. This year visits to Howes Creek Farm and the Mansfield Zoo were enjoyed by various residents. The Auxiliary is keen to support opportunities which enable residents to join in community events. The Auxiliary liaises with the Nurse Manager and Activities team to keep abreast of any items which may benefit the residents.

We continue to seek new members to the Auxiliary, and new ideas for fundraising. We are greatly assisted by support from local businesses and members of the community as we continue to find ways to assist Bindaree. Sincere thanks to all who have assisted in so many ways over the past year.

Jan Cunningham
President

Norma Pearce
Secretary

Nature and range of services

Mansfield District Hospital is an acute medical, surgical and obstetric hospital with an attached Urgent Care Centre. Buckland House Nursing Home provides 30 beds for high level aged care while Bindaree Retirement Centre provides 42 aged care beds. The Primary Care Centre provides a visiting nursing service, community health nursing, a range of allied health services and health promotion and prevention services to the community. Community nurses visit Jamieson and Woods Point on a weekly basis.

Services offered by Mansfield District Hospital are:

- General Medicine
- General Surgery
- Obstetrics
- Renal Dialysis
- Urgent Care
- Community Health
- Health Promotion
- Residential Aged Care
- Visiting Nursing
- Medical Imaging

The health service serves the catchment of Mansfield Shire with a population of 8,200 residents. In holiday seasons this population can increase three-fold.

Administrative structure

Board of Directors

Directors
Mrs Rosalind Adams
Mr Murray Beattie
Mrs Gill Belle
Ms Karli Brkljacic (resigned 03/12/2018)
Dr Pamela Dalgliesh
Assoc Prof Jane Freemantle
Prof Brenda Happell
Ms Katie Lockey
Mr Phillip Officer
Ms Laurie Watters (resigned 13/11/2018)

Audit & Risk Management
Mr Mark Evans (Community member)
Mr Geoff Gravenall (Community member)
Mr Jaya Naidu (Community member)
Mrs Rosalind Adams
Ms Katie Lockey
Mr Phillip Officer

Chair, Board of Directors
Mr Phillip Officer

Chair, Audit & Risk Management
Mr Jaya Naidu

Chair, Safety & Quality
Dr Pamela Dalgliesh

Chair, Finance
Mr Murray Beattie

Chair, Governance, Nominations and Executive Performance
Mrs Gill Belle

Chair, Community Advisory
Mrs Rosalind Adams

Chair, Health Professionals Scope of Practice and Appointments
Assoc Prof Jane Freemantle

Executive

Chief Executive Officer
Mr Cameron Butler, RN, B. Bus

Director of Clinical Services
Ms Margaretanne Hood, RN, RM, BN, Cert Neuroscience

Director of Medical Services
Dr John Elcock, BMedSci (Hons), MB BS, MBA, FRACGP, FRACMA, GAICD (to 21/11/2018)
Dr Campbell Miller MBChB, MBA, FRACMA (from 28/11/2018)

Director of Operations
Ms Melanie Green, BSci(Speech Pathology) MHHSM, GradDIP Risk & Bus Continuity

Director of Quality & Safety
Ms Anne Jewitt, RN, RM, IBCLC

Executive Assistant
Ms Tracy Rekers

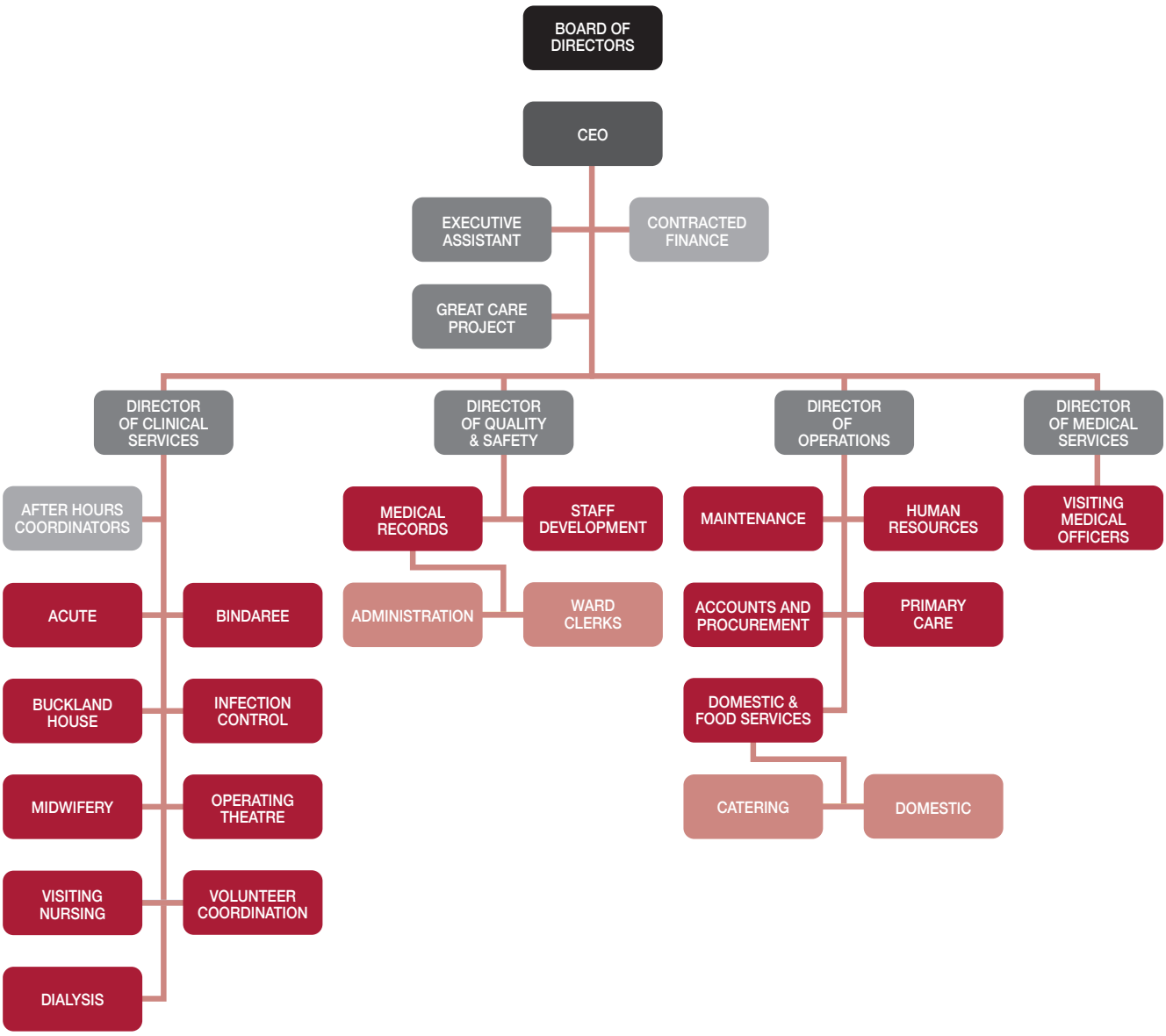
Visiting Medical Officers

Dr S Begin, MB, BS, FRACGP
Dr L Carter, MB, BS, BSC (Hons), FRACRM, FRACGP
Dr D Cook, MB BS, FACRRM, FRACGP
Dr E Dirksen, MB, BS
Dr D Friday, MB, BS, DRANZCOG, FRACGP
Dr J Hall, MB, BS
Dr J Harper, MB, BS
Dr T Ibrahim, MB, BS, DRANZCOG, FRACGP
Dr D Le Brocque, MB, BS
Dr M Morrissey, MB, BS, BSc, DCH, DRANZCOG
Dr B Nally, MB, BS
Dr J Penate, MB, BS
Dr R Radford, MB, BS
Dr M Reed, MB, BS, FRACGP
Dr M Sathveegarajah, MD, BSC
Dr G Slaney, MB, BS, DRANZCOG, FRACGP, MPH, DA DRCOG, FACRRM
Dr P Swart, MB, BS, FRACP, RACGP
Dr W Twycross, MB, BS, DA, DRANZCOG, DTPH
Dr A Wettenhall, MB, BS, FRACGP

Visiting Specialists

Dr L Dhakal, MB, BS, FRACP, MD, MPH
Dr M Forbes, MB, BS, FRACS
Dr K Ibrahim, MB, BS, FANZCA
Dr P MacLeish, MB, BS, FRACP
Dr A MacLeod, MB, BS (Hons), FRACS
Assoc Prof F Miller, MB, BS, PhD, FRACS
Dr S Pearce, MB, BS, FRANZCOG
Mr W Seager, MB, BS, FRACS (Ortho)

Organisational Structure



Responsible Bodies Declaration

In accordance with the *Financial Management Act 1994*, I am pleased to present the report of operations for Mansfield District Hospital for the year ending 30 June 2019.

Phillip Officer
Board Chair
Mansfield District Hospital

10 September 2019

MANSFIELD DISTRICT HOSPITAL

Workforce

Mansfield District Hospital adheres to the public sector employment principles. These help to shape the working environment we offer to our employees. They assist in maintaining the workplace culture whereby there are productive and harmonious working relationships, employees are treated well, have career opportunities and can safely raise their concerns.

In addition, the organisation has developed its own set of beliefs and values:

- QUALITY – We believe in providing a high quality, effective and accessible health service that reflects best practice.
- INTEGRITY – We believe it imperative to be open, honest, transparent and ethical in our decision-making and business transactions.
- SUPPORT – We believe in providing a respectful, safe, fair and equitable environment for our staff where scholarship is valued and professional development is advanced.
- SUSTAINABILITY – We believe in sustainable business and environmental practice.

All employees have been correctly classified in workforce data collections.

Hospitals Labour Category	JUNE Current Month FTE		Average Monthly FTE	
	2018	2019	2018	2019
Nursing	66.09	67.40	65.81	67.67
Administration and Clerical	14.71	16.27	13.11	15.27
Medical Support	1.39	0.75	0.77	0.58
Hotel and Allied Services	45.82	46.19	46.68	45.33
Medical Officers	–	–	–	–
Hospital Medical Officers	–	–	–	–
Sessional Clinicians	N/A	N/A	N/A	N/A
Ancillary Staff (Allied Health)	4.59	5.84	4.40	5.41
TOTAL	**132.60**	**136.45**	**130.77**	**134.26**

The FTE figures in the table above are those excluding overtime. These do not include contracted staff (e.g. Agency nurses, Fee-for-Service Visiting Medical Officers) who are not regarded as employees for this purpose. The above data should be consistent with the information provided in the Minimum Employee Data Set.

Occupational Health and Safety

Mansfield District Hospital is a responsible leader in the safety of its employees, consumers and members of the public. The Health Service complies with the requirements of the Occupational Health and Safety Act (Vic) 2004 and the Victorian Occupational Health and Safety Regulations 2017.

The Service continues to work with Health and Safety Representatives to eliminate or mitigate the risk of injury within the workplace. Where injury has occurred, the organisation seeks to achieve the safe, appropriate and timely Return to Work of its employees.

Reported Incidents

Year	Incidents	Incidents per 100 FTE
2018–19	40	29
2017–18	41	31
2016–17	38	30

There remains a strong emphasis on reducing workplace injuries. The Occupational Health and Safety Committee takes a proactive approach to dealing with matters of workplace safety. Training has been provided for representatives of the committee. Staff continue to be encouraged to report incidents and workplace hazards.

Reported Hazards

Year	Hazards	Hazards per 100 FTE
2018–19	13	9
2017–18	22	17
2016–17	6	5

Hazard and near miss reporting is encouraged as it as it allows for the identification and rectification of potential sources of workplace injury.

Lost Time Standard Claims

Year	Lost Time Claims	Lost Time Claims per 100 FTE Employees	Days Lost	Payments to Date	Average Cost per Claim	Estimation of Outstanding Claims Costs
2018–19	1	0.8	19	$1,304	$1,304	Nil
2017–18	1	0.8	72	$20,307	$20,307	Nil
2016–17	3	2.4	11	$1,958	$653	Nil

In 2018–19 there was one claim resulting in lost time. The staff member was proactively managed to return safely to work and transition to normal duties in a supported capacity.

Occupational Violence

Occupational Violence Statistics	2018–19
WorkCover accepted claims with an occupational violence cause per 100 FTE	0
Number of accepted WorkCover claims with lost time injury with an occupational violence cause per 1,000,000 hours worked	0
Number of occupational violence incidents reported	20
Number of occupational violence incidents reported per 100 FTE	14.89
Percentage of occupational violence incidents resulting in a staff injury, illness or condition	0

Definitions

For the purposes of the above statistics the following definitions apply

- **Occupational violence** – any incident where an employee is abused, threatened or assaulted in circumstances arising out of, or in the course of their employment.
- **Incident** – an event or circumstance that could have resulted in, or did result in, harm to an employee. Incidents of all severity ratings are included. Code Grey reporting is not included, however, if an incident occurred during the course of a planned or unplanned Code Grey it is included.
- **Accepted WorkCover claims** – accepted WorkCover claims that were lodged in 2018–19
- **Lost time** – lost time is defined as greater than one day.
- **Injury, illness or condition** – includes all reported harm as a result of the incident, regardless of whether the employee required time off work or submitted a claim.

Financial Results

Summary of Financial Results for last five years

	2019 $000	2018 $000	2017 $000	2016 $000	2015 $000
Net operating result*	**279**	**67**	**229**	**338**	**(193)**
Total revenue	19,695	18,276	20,528	15,972	14,933
Total expenses	(19,109)	(18,234)	(17,711)	(16,512)	(15,614)
Net result from transactions	**586**	**42**	**2,817**	**(540)**	**(681)**
Total other economic flows	(133)	6	82	0	0
Net result	**453**	**48**	**2,899**	**(540)**	**(681)**
Total assets	48,777	40,118	39,466	34,563	30,804
Total liabilities	(16,503)	(16,695)	(16,092)	(14,547)	(10,248)
Net assets/Total equity	**32,274**	**23,423**	**23,374**	**20,017**	**20,556**

Reconciliation between the Net result from transactions reported in the model to the Operating result as agreed in the Statement of Priorities

	2019 $000	2018 $000
Net operating result*	**279**	**67**
Capital and specific items		
Capital purpose and specific income	1,807	1,762
Assets provided free of charge	0	0
Expenditure for capital purpose	(39)	(304)
Depreciation and amortisation	(1,454)	(1,480)
Impairment of non-financial assets	0	0
Finance costs (other)	(7)	(3)
Net results from transactions	**586**	**42**

*The Net operating result is the result which the health service is monitored against in its Statement of Priorities.

As at 30 June 2019 the health service reported a net operating surplus of $279,000 in comparison to the previous year's result of a $67,000 surplus. A contributing factor to this result was the increase in both State and Commonwealth revenue. Salaries and wage expenses increased as a result of the employment of additional staff to assist us to meet our commitment to providing safe and high quality health care as well as through employment agreement wage increases.

Consultancies

Details of consultancies (under $10,000)

In 2018–19 there were 9 consultancies where the total fees payable to the consultants were less than $10,000 (exc. GST). The total expenditure during 2018–19 in relation to these consultancies is $18,764 (exc. GST).

Details of consultancies (valued at $10,000 or greater)

In 2018–19 there were 3 consultancies where the total fees payable to the consultants were $10,000 or greater (exc. GST). The total expenditure incurred during 2018–19 in relation to these consultancies is $69,233.

Consultant	Purpose of Consultancy	Start Date	End Date	Total Approved Project Fee (excl. GST)	Expenditure 2018–2019 (excl. GST)	Future Expenditure (excl. GST)
The JTA Corporation Pty Ltd	Workcover premium evaluation	August 2018	September 2018	$16,000	$15,633	Nil
The Penington Institute	Evaluation of Mansfield Restart	November 2018	Ongoing	$15,000	$10,500	$4,500
Cube Group Management Consulting	Strategic Planning	June 2019	Ongoing	$86,900	$43,100	$43,800

Information and Communication Technology (ICT) expenditure

The total ICT expenditure incurred during 2018–19 is $621,816 (excluding GST) with the details shown below.

Business As Usual (BAU) ICT expenditure	Non-Business As Usual (non-BAU) ICT expenditure		
Total (excluding GST)	**Total = Operational expenditure and capital expenditure (excl. GST)**	**Operational expenditure (excl. GST)**	**Capital expenditure (excl. GST)**
$621,816	Nil	Nil	Nil

Disclosures Required Under Legislation

Freedom of Information Act 1982

The organisation is subject to the provisions of the *Freedom of Information Act 1982.*

In 2018–19 there were 19 applications made to the organisation under these provisions. All requests were approved and processed.

Freedom of Information applications are made to the Freedom of Information Officer and are dealt with in accordance with the Act. Any charges applied are in accordance with the Act and Regulations.

Information on making a Freedom of Information request can be found at http://mdh.org.au/contact/make-a-foi-request/. Applications may be submitted by post or in person.

Building Act 1993

Mansfield District Hospital has met the requirements of the *Building Act 1993* in accordance with DHS Capital Development Guidelines (Minister for Finance Guideline Building Act 1993/Standards for Publicly Owned Buildings 1994/Building (Interim) Regulations 2005 and Building Code of Australia 2004).

Protected Disclosure Act 2012

Complaints about certain serious misconduct or corruption involving public health services in Victoria can be made by individuals directly to the Independent Broad-based Anti-corruption Commission (IBAC). Mansfield District Hospital encourages individuals to raise their concerns about corrupt or improper conduct directly with IBAC.

Mansfield District Hospital is committed to extend the protections under the *Protected Disclosure Act 2012* (Vic) to individuals who make protected disclosures under that Act, or who cooperate with investigations into protected disclosures. Websites of interest for complaint procedures regarding this Act are: http://www.ombudsman.vic.gov.au and http://www.health.vic.gov.au/hsc

No disclosures were made in 2018–19.

National Competition Policy

Mansfield District Hospital complies with the National Competition Policy and with the requirements of the *Competitive Neutrality Policy Victoria.*

Carers Recognition Act 2012

The organisation recognises and supports its responsibilities and obligations under the Act for people in care relationships and the role of carers in our community. Mansfield District Hospital has strategies and actively works with carers to find ways for people in care relationships to have a say in care planning and service delivery complying with all requirements of the Act.

Environmental Performance

Reducing the impact of our health services on the environment is a priority area for Mansfield District Hospital. A commitment to install 167 solar panels was made in 2017–18. Tenders for the supply and installation have been undertaken and are currently with Health Purchasing Victoria.

Additional information available upon request

Details in respect of the items listed below have been retained by the health service and are available to the relevant Ministers, Members of Parliament and the public on request (subject to the freedom of information requirements, if applicable):

- Declarations of pecuniary interests have been duly completed by all relevant officers
- Details of shares held by senior officers as nominee or held beneficially;
- Details of publications produced by the entity about itself, and how these can be obtained;
- Details of changes in prices, fees, charges, rates and levies charged by the Health Service;
- Details of any major external reviews carried out on the Health Service;
- Details of major research and development activities undertaken by the Health Service that are not otherwise covered either in the report of operations or in a document that contains the financial statements and report of operations;
- Details of overseas visits undertaken including a summary of the objectives and outcomes of each visit;
- Details of major promotional, public relations and marketing activities undertaken by the Health Service to develop community awareness of the Health Service and its services;
- Details of assessments and measures undertaken to improve the occupational health and safety of employees;
- A general statement on industrial relations within the Health Service and details of time lost through industrial accidents and disputes, which is not otherwise detailed in the report of operations;
- A list of major committees sponsored by the Health Service, the purposes of each committee and the extent to which those purposes have been achieved;
- Details of all consultancies and contractors including consultants/contractors engaged, services provided, and expenditure committed for each engagement.

Other relevant reporting directives

Local Jobs First Policy

There were no contracts undertaken requiring reporting in this category in 2018–19.

Financial Management Compliance attestation

I, Phillip Officer, on behalf of the Responsible Body, certify that Mansfield District Hospital has complied with the applicable Standing Directions of the Assistant Treasurer under the Financial Management Act 1994 and Instructions.

Phillip Officer
Board Chair
Mansfield District Hospital
10 September 2019

Attestations

Data Integrity

I, Cameron Butler, certify that Mansfield District Hospital has put in place appropriate internal controls and processes to ensure that reported data accurately reflects actual performance. Mansfield District Hospital has critically reviewed these controls and processes during the year.

Cameron Butler
Accountable Officer
Mansfield District Hospital
10 September 2019

Conflict of Interest

I, Cameron Butler, certify that Mansfield District Hospital has put in place appropriate internal controls and processes to ensure that it has complied with the requirements of hospital circular 07/2017 Compliance reporting in health portfolio entities (Revised) and has implemented a *Conflict of Interest* policy consistent with the minimum accountabilities required by the VPSC. Declaration of private interest forms have been completed by all executive staff within Mansfield District Hospital and members of the Board, and all declared conflicts have been addressed and are being managed. Conflict of interest is a standard agenda item for declaration and documentation at each executive board meeting.

Cameron Butler
Accountable Officer
Mansfield District Hospital
10 September 2019

Integrity, Fraud and Corruption

I, Cameron Butler, certify that Mansfield District Hospital has put in place appropriate internal controls and processes to ensure that integrity, fraud and corruption have been reviewed and addressed at Mansfield District Hospital during the year.

Cameron Butler
Accountable Officer
Mansfield District Hospital
10 September 2019

Statement of Priorities

Part A – Strategic Priorities for 2018–19

The Statement of Priorities is an accountability agreement between Mansfield District Hospital and the Minister for Health containing key performance expectations, targets and funding for the year as well as government service priorities.

Goals	Strategies	Health Service Deliverables	Outcome
Better Health A system geared to prevention as much as treatment. Everyone understands their own health and risks. Illness is detected and managed early. Healthy neighbourhoods and communities encourage healthy lifestyles.	**Better Health** Reduce Statewide risks. Build healthy neighbourhoods. Help people to stay healthy. Target health gaps.	Implement Mansfield RESTART, a community-led program to address addiction and substance use in the Mansfield community.	Achieved. Mansfield RESTART has been implemented. As at 30 June 2019 there has been more than sixty referrals into the program, surpassing expectations when establishing the program. There has been strong support from local GPs, police and the court system.
Better Access Care is always there when people need it. More access to care in the home and community. People are connected to the full range of care and support they need. There is equal access to care.	**Better Access** Plan and invest. Unlock innovation. Provide easier access. Ensure fair access.	Implement Great Care @ MDH, a model of care based on enhancing the consumer experience at the point of care.	Achieved. The first stage of Great Care @ MDH has been implemented and has involved strong consumer and staff engagement. In excess of two hundred people have provided input into the program.
Better Care Target zero avoidable harm. Healthcare that focusses on outcomes. Patients and carers are active partners in care. Care fits together around people's needs.	**Better Care** Put quality first. Join up care. Partner with patients. Strengthen the workforce. Embed evidence. Ensure equal care. Better care.	Implement Great Care @ MDH to enable better care through focussing on the individual and collaborating with consumers to produce better health outcomes.	Achieved. The first stage of Great Care @ MDH has been implemented and has involved strong consumer and staff engagement. In excess of two hundred people have provided input into the program.
Specific 2018–19 priorities (mandatory)	**Disability Action Plans** Draft disability action plans are completed in 2018–19.	Develop a Mansfield District Hospital Diversity and Equity Plan to ensure that the organisation meets the needs of its consumers and employees with a disability.	Achieved. Diversity and Equity Plan complete and incorporated in the health service's Charter for Inclusion.
	Volunteer engagement Ensure that the health service executives have appropriate measures to engage and recognise volunteers.	Review the model of volunteer engagement to ensure that volunteers from a wide range of backgrounds are engaged in a meaningful way, actively contribute to the consumer experience and are recognised for their contribution to the organisation.	Achieved. Volunteer program has been reviewed and coordination of volunteers has been expanded. This has resulted in the recruitment of additional volunteers with a diverse range of skills and backgrounds.

Goals	Strategies	Health Service Deliverables	Outcome
Specific 2018–19 priorities (mandatory) continued	**Bullying and harassment** Actively promote positive workplace behaviours and encourage reporting. Utilise staff surveys, incident reporting data, outcomes of investigations and claims to regularly monitor and identify risks related to bullying and harassment, in particular include as a regular item in Board and Executive meetings. Appropriately investigate all reports of bullying and harassment and ensure there is a feedback mechanism to staff involved and the broader health service staff.	Actively work with staff to promote positive workplace behaviours and proactively address behaviours that are inconsistent with organisational values.	Achieved. All staff have been educated in positive workplace behaviour. Acceptable workplace behaviours have been reviewed in conjunction with staff and the organisational values are currently under review.
	Occupational violence Ensure all staff who have contact with patients and visitors have undertaken core occupational violence training, annually. Ensure the department's occupational violence and aggression training principles are implemented.	Continue to provide a safer workplace for employees through the implementation of the Occupational Violence Plan.	Achieved. Occupational Violence Plan continues to be implemented. Expansion of CCTV and installation of swipe card access has occurred.
	Environmental Sustainability Actively contribute to the development of the Victorian Government's policy to be net zero carbon by 2050 and improve environmental sustainability by identifying and implementing projects, including workforce education, to reduce material environmental impacts with particular consideration of procurement and waste management, and publicly reporting environmental performance data, including measurable targets related to reduction of clinical, sharps and landfill waste, water and energy use and improved recycling.	Actively promote environmental sustainability through the implementation of initiatives to reduce carbon emissions, such as the installation of solar panels and reducing waste.	Achieved in part. Tendered in conjunction with Health Purchasing Victoria. Tender evaluation completed and awaiting installation.
	LGBTI Develop and promulgate service level policies and protocols, in partnership with LGBTI communities, to avoid discrimination against LGBTI patients, ensure appropriate data collection, and actively promote rights to free expression of gender and sexuality in healthcare settings. Where relevant, services should offer leading practice approaches to trans and intersex related interventions.	Develop a Mansfield District Hospital Diversity and Equity Plan to ensure that the organisation meets the needs of its LGBTI consumers and employees.	Achieved. Diversity and Equity Plan complete and incorporated in the health service's Charter for Inclusion.

Part B – Performance Priorities

High Quality and Safe Care

Key performance indicator	Target	Result
Accreditation		
Accreditation against the National Safety and Quality Health Service Standards	Accredited	Full compliance
Compliance with the Commonwealth Aged Care Accreditation Standards	Accredited	Full compliance
Infection prevention and control		
Compliance with Hand Hygiene Australia program	80%	86%
Percentage of healthcare workers immunised for Influenza	80%	97%
Patient experience		
Victorian Healthcare Experience Survey – data submission	Full compliance	Full compliance
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – Quarter 1	95%	97%
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – Quarter 2	95%	100%
Victorian Healthcare Experience Survey – percentage of positive patient experience responses – Quarter 3	95%	98%
Victorian Healthcare Experience Survey – percentage of very positive responses to questions on discharge care – Quarter 1	75%	86%
Victorian Healthcare Experience Survey – percentage of very positive responses to questions on discharge care – Quarter 2	75%	97%
Victorian Healthcare Experience Survey – percentage of very positive responses to questions on discharge care – Quarter 3	75%	93%
Victorian Healthcare Experience Survey – patients' perception of cleanliness – Quarter 1	70%	94%
Victorian Healthcare Experience Survey – patients' perception of cleanliness – Quarter 2	70%	94%
Victorian Healthcare Experience Survey – patients' perception of cleanliness – Quarter 3	70%	94%
Adverse events		
Sentinel events – root cause analysis (RCA) reporting	All RCA reports submitted within 30 business days	Nil
Maternity and newborn		
Rate of singleton term infants without birth anomalies with APGAR score <7 to 5 minutes	≤ 1.4%	2.9%

Strong Governance, Leadership and Culture

Key performance indicator	Target	Result
Organisational culture		
People Matter Survey – percentage of staff with an overall positive response to safety and culture questions	80%	97%
People Matter Survey – percentage of staff with a positive response to the question *"I am encouraged by my colleagues to report any patient safety concerns I may have"*	80%	97%
People Matter Survey – percentage of staff with a positive response to the question *"Patient care errors are handled appropriately in my work area"*	80%	99%
People Matter Survey – percentage of staff with a positive response to the question *"My suggestions about patient safety would be acted upon if I expressed them to my manager"*	80%	98%
People Matter Survey – percentage of staff with a positive response to the question *"The culture in my work area makes it easy to learn from the errors of others"*	80%	95%

Key performance indicator	Target	Result
People Matter Survey – percentage of staff with a positive response to the question *"Management is driving us to be a safety-centred organisation"*	80%	99%
People Matter Survey – percentage of staff with a positive response to the question *"The health service does a good job of training new and existing staff"*	80%	95%
People Matter Survey – percentage of staff with a positive response to the question *"Trainees in my discipline are adequately supervised"*	80%	95%
People Matter Survey – percentage of staff with a positive response to the question *"I would recommend a friend or relative to be treated as a patient here"*	80%	97%

Effective Financial Management

Key performance indicator	Target	Result
Finance		
Operating result ($m)	0.02	0.28
Average number of days to paying trade creditors	60 days	48 days
Average number of days to receiving patient fee debtors	60 days	25 days
Adjusted current asset ratio	0.7 or 3% improvement from health service base target	1.39
Actual number of days a health service can maintain its operations with unrestricted available cash, measured on the last day of each month.	14 days	174.40
Measures the accuracy of forecasting the Net result from transactions (NRFT) for the current financial year ending 30 June.	Variance ≤ $250,000	Achieved

Part C – Activity and funding

Funding type	2018–19 Achievement	Units
Acute Admitted		
Public	762.2	WIES
Private	243.8	WIES
TOTAL PPWIES (Public and Private)	1,006.0	
Renal	49.9	WIES
DVA	17.21	WIES
TAC	2.26	WIES
NBCSP	4.28	WIES
TOTAL	1,079.65	
Health Workforce	3	Graduate positions
Aged Care		
• Buckland House Nursing Home	75%	Occupancy
• Bindaree Retirement Centre	95%	Occupancy
Visiting Nursing Service		
Small Rural HACC	591	Contact hours
Commonwealth Home Support Program	2,812	Contact hours
Community Health		
Initial Needs identification	371	Contact hours
Nursing	1,137	Contact hours
Allied Health		
• Counselling/Casework	345	Contact hours
• Dietetics	259	Contact hours
• Occupational Therapy	282	Contact hours
• Physiotherapy	585	Contact hours
• Speech Pathology	453	Contact hours
TOTAL	3,432	Contact hours

Life Governors

Mansfield District Hospital Life Governors

Ms J Acaster
Mrs J Adams
Mrs M E Black
Mrs N Buckland
Mr O Buttula
Mrs C Cameron
Mr H B Clark
Mrs J Clark
Mrs N Corr
Mrs B Cox
Mrs C Cox
Mr J M Cummins
Dr J M Curtis
Mr C Durran
Mrs M Egan
Dr H R Esser
Mr W H Glen
Mrs R Gray
Sir A Grimwade
Mr T Gunnerson
Mrs M Hood
Mr P Howarth
Mrs B Hughes
Mrs D Kilford
Mrs Z Kirley
Mr P McCann
Mrs V McCormack
Dr P Mackay
Mr A Maxwell-Davis
Mr H A Nix
Mrs W Nix
Mrs Y O'Connor
Mrs S Parsons
Mr W E Parsons
Mr G Ritchie
Miss F B Shaw
Mr G Smith
Mr A Tehan
Mr C Thomas
Miss S M Turner
Miss B Walsh
Mr F Wickham
Mr D T Yencken

Bindaree Retirement Centre Life Governors

G Adamson
L R Carter
C C Crawford
M L Evans
R D Gunning
V C McCormack
E Mahoney
E O'Brien
T M R Ryan
H D T Williamson

Donor and Contributors

Major Donors

B Gale	$10,000.00
RAJ & JL Murphy	$50,760.00
Community Association for Woods Point	$6,000.00
Mansfield Golf Club Trade Golf Day	$17,960.00
Marks Super IGA	$7,198.00
The Peter Mackay Bequest	$38,588.90

Donors contributing more than $100 up to $5,000

JS & RA Adams
J Anderson
S Andrews
M Attley
M Awais
E Balson
EF Balson
JC & CM Barling
J Beavis
F Brega
HN Brook
J Canavan
C Chaston
M Clay
R Collins
G Collins
B Cooper
A & A Curinier
M Dimitroff
D Edward
E Eisner
J Eisner
J Esser
ML & JW Fitzpatrick
A & D Foster
N Friday
J Giddons
H & R Gogol
NA Guttridge
K Hall
J Hall
Mr Healy
G Hissenkemper
B Hodges
A Houghton
P Howie
M Hume
D Hume
T Humphrey
H Iberg
S Ischovits
GC & FJ James
S Kinsmore
D Kynnersley
A Lahore
D Lowden
M Mark
BJ & MJ Martin
W Maxwell
J McAllister
R McCrae
E McLeod
R Nizel
S O'Brien
P & R Officer
L & D O'Keefe
D Oppenheim
K Ord
D Ord
G Padbury
B Parsons
J Pilbrow
Y Pollard
J & F Pollard
S & J Purcell
AW & B Rekers
GC Richardson
M Robinson
C Rochford
E Rogers
J Ross
T & N Ross
E Roux
J Seeper
E Seidel
H Steigerwald
B Stinson
T & J Tehan
SJ Templeton
BE Trevaskis
T Velevski
E Vrcancic
AF Walsh
S White
V Wilson
Briner Family
Ivotek Industries Pty Ltd
Mansfield Lakeside Ski Village Pty Ltd
Mitch's Plastering Service
Equity Trustees
Amcal Pharmacy
Chapman Garden Landscapes
Mansfield Newsagency
FoodWorks
Goughs Bay Festival
M & A McCormack
Small Business Network
Robbo's Glass
Alpine Country Car Club Jamieson
The Harry and Clare Friday Foundation
Mt Buller and Mt Stirling Alpine Resort Management Board

Other reporting requirements

Compliance with Health Purchasing Victoria (HPV) Health Purchasing Policies

I, Cameron Butler, certify that Mansfield District Hospital has put in place appropriate internal controls and processes to ensure that it has complied with the requirements set out in the HPV Health Purchasing Policies including mandatory HPV collective agreements as required by the Health Services Act 1988 (Vic) and has critically reviewed these controls and processes during the year.

Cameron Butler
Accountable Officer
Mansfield District Hospital
10 September 2019

Safe Patient Care Act 2015

The hospital has no matters to report in relation to its obligations under section 40 of the Safe Patient Care Act 2015.

Mansfield District Hospital

ABN 65 866 548 895

Financial Statements for the Financial Year ended 30 June 2019

Independent Auditor's Report

Victorian Auditor-General's Office

To the Board of Mansfield District Hospital

Opinion	I have audited the financial report of Mansfield District Hospital (the health service) which comprises the: • balance sheet as at 30 June 2019 • comprehensive operating statement for the year then ended • statement of changes in equity for the year then ended • cash flow statement for the year then ended • notes to the financial statements, including significant accounting policies • board member's, accountable officer's and chief finance & accounting officer's declaration. In my opinion the financial report presents fairly, in all material respects, the financial position of the health service as at 30 June 2019 and their financial performance and cash flows for the year then ended in accordance with the financial reporting requirements of Part 7 of the *Financial Management Act 1994* and applicable Australian Accounting Standards.
Basis for Opinion	I have conducted my audit in accordance with the *Audit Act 1994* which incorporates the Australian Auditing Standards. I further describe my responsibilities under that Act and those standards in the *Auditor's Responsibilities for the Audit of the Financial Report* section of my report. My independence is established by the *Constitution Act 1975.* My staff and I are independent of the health service in accordance with the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110 *Code of Ethics for Professional Accountants* (the Code) that are relevant to my audit of the financial report in Victoria. My staff and I have also fulfilled our other ethical responsibilities in accordance with the Code. I believe that the audit evidence I have obtained is sufficient and appropriate to provide a basis for my opinion.
Board's responsibilities for the financial report	The Board of the health service is responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards and the *Financial Management Act 1994*, and for such internal control as the Board determines is necessary to enable the preparation and fair presentation of a financial report that is free from material misstatement, whether due to fraud or error. In preparing the financial report, the Board is responsible for assessing the health service's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless it is inappropriate to do so.

Level 31 / 35 Collins Street, Melbourne Vic 3000
T 03 8601 7000 enquiries@audit.vic.gov.au www.audit.vic.gov.au

Auditor's responsibilities for the audit of the financial report

As required by the *Audit Act 1994,* my responsibility is to express an opinion on the financial report based on the audit. My objectives for the audit are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes my opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

As part of an audit in accordance with the Australian Auditing Standards, I exercise professional judgement and maintain professional scepticism throughout the audit. I also:

- identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for my opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the health service's internal control
- evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the Board
- conclude on the appropriateness of the Board's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the health service's ability to continue as a going concern. If I conclude that a material uncertainty exists, I am required to draw attention in my auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify my opinion. My conclusions are based on the audit evidence obtained up to the date of my auditor's report. However, future events or conditions may cause the health service to cease to continue as a going concern.
- evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.

I communicate with the Board regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that I identify during my audit.

MELBOURNE
13 September 2019

Travis Derricott
as delegate for the Auditor-General of Victoria

FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2019

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Board Member's, Accountable Officer's and Chief Finance & Accounting Officer's Declaration

The attached financial statements for Mansfield District Hospital have been prepared in accordance with Direction 5.2 of the Standing Directions of the Assistant Treasurer under the Financial Management Act 1994, applicable Financial Reporting Directions, Australian Accounting Standards including Interpretations, and other mandatory professional reporting requirements

We further state that, in our opinion, the information set out in the comprehensive operating statement, balance sheet, statement of changes in equity, cash flow statement and accompanying notes, presents fairly the financial transactions during the year ended 30 June 2019 and the financial position of Mansfield District Hospital as at 30 June 2019.

At the time of signing we are not aware of any circumstance which would render any particulars included in the financial report to be misleading or inaccurate.

We authorise the attached financial statements for issue on 10th September 2019.

Mr P. Officer
Board Chair

Mansfield

10-Sep-19

Mr C. Butler
Chief Executive Officer

Mansfield

10-Sep-19

Mr M. Fagence
Financial Services
Northeast Health Wangaratta

Mansfield

10-Sep-19

Mansfield District Hospital

COMPREHENSIVE OPERATING STATEMENT

for the Financial Year Ended 30 June 2019

	Note	2019 $'000	2018 $'000
Income From Transactions			
Operating Activities	2.1	18,407	17,142
Non-Operating Activities	2.1	739	672
Other Income	2.1	549	448
Total Income from Transactions		**19,695**	**18,262**
Expenses From Transactions			
Employee Expenses	3.1	(13,720)	(12,770)
Supplies and Consumables	3.1	(1,078)	(1,181)
Finance costs	3.1	(7)	(3)
Depreciation and Amortisation	4.4	(1,454)	(1,480)
Other Operating Expenses	3.1	(2,837)	(2,592)
Other Non-Operating Expenses	3.1	(13)	(194)
Total Expenses from Transactions		**(19,109)**	**(18,220)**
Net Result from Transactions – Net Operating Balance		**586**	**42**
Other Economic Flows included in Net Result			
Net Gain / (Loss) on Sale of Non Financial Assets	3.2	–	16
Other Gain / (Loss) from Other Economic Flows	3.2	(133)	(10)
Total Other Economic Flows included in Net Result		**(133)**	**6**
Net Result for the Year		**453**	**48**
Other Comprehensive Income			
Items that will not be reclassified to Net Result			
Changes in Property, Plant and Equipment Revaluation Surplus	4.2(b)	8,398	–
Total Other Comprehensive Income		**8,398**	**–**
Comprehensive Result for the year		**8,851**	**48**

This Statement should be read in conjunction with the accompanying notes.

Mansfield District Hospital

BALANCE SHEET

as at 30 June 2019

	Note	2019 $'000	2018 $'000
Current Assets			
Cash and Cash Equivalents	6.2	20,299	1,117
Receivables	5.1	419	682
Investments	4.1	–	17,737
Inventories		77	76
Other Assets		347	341
Total Current Assets		**21,142**	**19,953**
Non-Current Assets			
Receivables	5.1	686	802
Property, Plant and Equipment	4.2	26,926	19,344
Intangible Assets	4.3	23	19
Total Non-Current Assets		**27,635**	**20,164**
TOTAL ASSETS		**48,777**	**40,117**
Current Liabilities			
Payables	5.2	1,024	1,314
Lease Liabilities	6.1	16	17
Provisions	3.4	3,235	2,747
Other Liabilities	5.3	12,012	12,176
Total Current Liabilities		**16,287**	**16,254**
Non-Current Liabilities			
Lease Liabilities	6.1	13	17
Provisions	3.4	203	424
Total Non-Current Liabilities		**216**	**441**
TOTAL LIABILITIES		**16,503**	**16,695**
NET ASSETS		**32,274**	**23,423**
EQUITY			
Property, Plant and Equipment Revaluation Surplus	4.2f	25,101	16,703
Contributed Capital		10,853	10,853
Accumulated Deficits		(3,680)	(4,133)
TOTAL EQUITY		**32,274**	**23,423**

This Statement should be read in conjunction with the accompanying notes.

Mansfield District Hospital

STATEMENT OF CHANGES IN EQUITY

for the Financial Year Ended 30 June 2019

	Property, Plant and Equipment Revaluation Surplus $'000	Contributions by Owners $'000	Accumulated Deficits $'000	Total $'000
Balance at 1 July 2017	16,703	10,853	(4,181)	23,375
Net Result for the Year	–	–	48	48
Other Comprehensive Income for the Year	–	–	–	–
Balance at 30 June 2018	**16,703**	**10,853**	**(4,133)**	**23,423**
Net Result for the Year	–	–	453	453
Other Comprehensive Income for the Year	8,398	–	–	8,398
Balance at 30 June 2019	**25,101**	**10,853**	**(3,680)**	**32,274**

This Statement should be read in conjunction with the accompanying notes.

Mansfield District Hospital

CASH FLOW STATEMENT

for the Financial Year Ended 30 June 2019

	Note	2019 $'000	2018 $'000
CASH FLOWS FROM OPERATING ACTIVITIES			
Operating Grants from Government		13,583	12,876
Capital Grants from Government		60	55
Patient and Resident Fees Received		2,187	1,921
Donations and Bequests Received		288	1,545
GST Received from / (paid to) ATO		1	1
Interest Received		739	671
Other Receipts		680	965
Total Receipts		***17,538***	***18,034***
Employee Expenses Paid		(11,657)	(11,841)
Fee for Service Medical Officers		(891)	(728)
Payments for Supplies and Consumables		(1,078)	(698)
Finance Costs		(7)	(3)
Other Payments		(1,649)	(2,821)
Total Payments		***(15,282)***	***(16,091)***
NET CASH FLOW FROM OPERATING ACTIVITIES	8.1	2,256	1,943
CASH FLOWS FROM INVESTING ACTIVITIES			
Purchase of Non-Financial Assets		(642)	(297)
Purchase of Investments (Term Deposits)		–	(4,326)
Proceeds from Disposal of Investments		17,737	–
Proceeds from Sale of Non-Financial Assets		–	25
NET CASH FLOW USED IN INVESTING ACTIVITIES		17,095	(4,598)
CASH FLOWS FROM FINANCING ACTIVITIES			
Repayment of Finance Leases		(5)	(22)
Net Repayment of Accommodation Deposits		(164)	(60)
NET CASH FLOW USED IN FINANCING ACTIVITIES		**(169)**	**(82)**
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS HELD		19,182	(2,737)
CASH AND CASH EQUIVALENTS AT BEGINNING OF FINANCIAL YEAR		1,117	3,854
CASH AND CASH EQUIVALENTS AT END OF FINANCIAL YEAR	6.2	**20,299**	**1,117**

This Statement should be read in conjunction with the accompanying notes.

NOTES TO THE FINANCIAL STATEMENTS

for the Financial Year Ended 30 June 2019

BASIS OF PRESENTATION

These financial statements are in Australian dollars and the historical cost convention is used unless a different measurement basis is specifically disclosed in the note associated with the item measured on a different basis.

The accrual basis of accounting has been applied in preparing these financial statements, whereby assets, liabilities, equity, income and expenses are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

These annual financial statements represent the audited general purpose financial statements for Mansfield District Hospital (ABN 65 866 548 895) for the period ending 30 June 2019. The purpose of the report is to provide users with information about the hospitals' stewardship of resources entrusted to it.

(a) Statement of compliance

These financial statements are general purpose financial statements which have been prepared in accordance with the *Financial Management Act 1994*, and applicable AASs, which include interpretations issued by the Australian Accounting Standards Board (AASB). They are presented in a manner consistent with the requirements of AASB 101 *Presentation of Financial Statements.*

The financial statements also comply with relevant Financial Reporting Directions (FRDs) issued by the Department of Treasury and Finance, and relevant Standing Directions (SDs) authorised by the Assistant Treasurer.

The hospital is a not-for profit entity and therefore applies the additional AUS paragraphs applicable to "not-for-profit" hospitals under the AASBs.

(b) Reporting Entity

The financial statements includes all the controlled activities of Mansfield District Hospital.

Its principal address is:
53 Highett Street
Mansfield Vic 3722

A description of the nature of Mansfield District Hospital's operations and its principal activities is included in the report of operations, which does not form part of these financial statements.

(c) Basis of accounting preparation and measurement

Accounting policies are selected and applied in a manner which ensures that the resulting financial information satisfies the concepts of relevance and reliability, thereby ensuring that the substance of the underlying transactions or other events is reported.

The accounting policies set out below have been applied in preparing the financial statements for the year ended 30 June 2019, and the comparative information presented in these financial statements for the year ended 30 June 2018.

The financial statements are prepared on a going concern basis (refer to Note 8.9 Economic Dependency).

These financial statements are presented in Australian Dollars, the functional and presentation currency of the Mansfield District Hospital.

The financial statements, except for cash flow information, have been prepared using the accrual basis of accounting. Under the accrual basis, items are recognised as assets, liabilities, equity, income or expenses when they satisfy the definitions and recognition criteria for those items, that is they are recognised in the reporting period to which they relate, regardless of when cash is received or paid.

All amounts shown in the financial statements have been rounded to the nearest thousand dollars, unless otherwise stated.

Judgements, estimates and assumptions are required to be made about the carrying values of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on professional judgements derived from historical experience and various other factors that are believed to be reasonable under the circumstances. Actual results may differ from these estimates.

Revisions to accounting estimates are recognised in the period in which the estimate is revised and also in future periods that are affected by the revision. Judgements and assumptions made by management in the application of AASs that have significant effects on the financial statements and estimates relate to:

- the fair value of land, buildings, plant and equipment (refer to Note 4.2);
- superannuation expense (refer to Note 3.5); and
- employee benefit provisions based on likely tenure of existing staff, patterns of leave claims, future salary movements and future discount rates (refer to Note 3.4).

NOTE 1: SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES (Continued)

Goods and Services Tax (GST)
Income, expenses and assets are recognised net of the amount of associated GST, unless the GST incurred is not recoverable from the Australian Taxation Office (ATO). In this case the GST payable is recognised as part of the cost of acquisition of the asset or as part of the expense.

Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the ATO is included with other receivables or payables in the Balance Sheet.

Cash flows are presented on a gross basis. The GST components of cash flows arising from investing or financing activities which are recoverable from, or payable to the ATO, are presented as operating cash flow.

Commitments and contingent assets and liabilities are presented on a gross basis.

(d) Jointly Controlled Operation

Joint control is the contractually agreed sharing of control of an arrangement, which exists only when decisions about the relevant activities require the unanimous consent of the parties sharing control.

In respect of any interest in joint operations, Mansfield District Hospital recognises in the financial statements:

- its assets, including its share of any assets held jointly;
- Any liabilities including its share of liabilities that it had incurred;
- It's revenue from the sale of its share of the output from the joint operation;
- Its share of the revenue from the sale of the output by the operation; and
- It's expenses, including its share of any expenses incurred jointly.

Mansfield District Hospital is a Member of the Hume Rural Health Alliance Joint Venture and retains joint control over the arrangement, which it has classified as a joint operation (refer to Note 8.8 Jointly Controlled Operations).

(e) Intersegment Transactions

Transactions between segments within Mansfield District Hospital have been eliminated to reflect the extent of hospital's operations as a group.

(f) Equity

Contributed Capital
Consistent with the requirements of AASB 1004 Contributions, contributions by owners (that is, contributed capital and its repayment) are treated as equity transactions and, therefore, do not form part of the income and expenses of the Mansfield District Hospital.

Transfers of net assets arising from administrative restructurings are treated as distributions to or contributions by owners. Transfers of net liabilities arising from administrative restructurings are treated as distributions to owners.

(g) Comparatives

Where applicable, the comparative figures have been restated to align with the presentation in the current year.

NOTE 2: FUNDING DELIVERY OF OUR SERVICES

The hospital's overall objective is to deliver programs and services that support and enhance the wellbeing of all Victorians

Mansfield District Hospital is predominantly funded by accrual based grant funding for the provision of outputs. The hospital also receives income from the supply of services.

Structure

2.1 Income from Transactions

NOTE 2.1: INCOME FROM TRANSACTIONS

	Total 2019 $'000	Total 2018 $'000
Government Grants – Operating	13,934	13,108
Government Grants – Capital	147	55
Other Capital purpose income – (including capital donations)	1,560	1,708
Patient and Resident Fees	2,364	2,021
Commercial Activities [1]	114	104
Other Revenue from Operating Activities (including non-capital donations)	288	146
Total Income from Operating Activities	**18,407**	**17,142**
Capital Interest	679	641
Other Interest	60	31
Total Income from Non-Operating Activities	**739**	**672**
Other Income – HRHA joint venture revenue	347	320
Other Income – education and sales of medical supplies	202	128
Total Other Income	**549**	**448**
Total Income from Transactions	**19,695**	**18,262**

1. Commercial activities represent business activities which health service enter into to support their operations.

NOTE 2.1: INCOME FROM TRANSACTIONS (Continued)

Revenue Recognition
Income is recognised in accordance with AASB 118 Revenue and is recognised as to the extent that it is probable that the economic benefits will flow to Mansfield District Hospital and the income can be reliably measured at fair value. Unearned income at reporting date is reported as income received in advance.

Amounts disclosed as revenue are, where applicable, net of returns, allowances and duties and taxes.

Government Grants and Other Transfers of Income (other than contributions by owners)
In accordance with AASB 1004 Contributions, government grants and other transfers of income (other than contributions by owners) are recognised as income when the hospital gains control of the underlying assets irrespective of whether conditions are imposed on the hospital's use of the contributions.

Department of Health and Human Services makes certain payments on behalf of the hospital. These amounts have been brought to account in determining the operating result for the year by recording them as revenue and expenses.

Contributions are deferred as income in advance when the hospital has a present obligation to repay them and the present obligation can be reliably measured.

Non-cash contributions from the Department of Health and Human Services
The Department of Health and Human Services makes some payments on behalf of health services as follows:

- The Victorian Managed Insurance Authority non-medical indemnity insurance payments are recognised as revenue following advice from the Department of Health and Human Services
- Long Service Leave (LSL) revenue is recognised upon finalisation of movements in LSL liability in line with the long service leave funding arrangements set out in the relevant Department of Health and Human Services Hospital Circular.

Patient and Resident Fees
Patient and resident fees are recognised as revenue on an accrual basis.

Revenue from Commercial Activities
Revenue from commercial activities such as catering and property rental income are recognised on an accrual basis.

Fair value of assets and services received free of charge or for nominal consideration
Resources received free of charge or for nominal consideration are recognised at their fair value when the transferee obtains control over them, irrespective of whether restrictions or conditions are imposed over the use of the contributions, unless received from another Health Service or agency as a consequence of a restructuring of administrative arrangements. In the latter case, such transfer will be recognised at carrying amount. Contributions in the form of services are only recognised when a fair value can be reliably determined and the service would have been purchased if not received as a donation.

Other Income
Other income includes non-property rental, dividends, forgiveness or liabilities and bad debt reversals.

Interest Revenue
Interest revenue is recognised on a time proportionate basis that takes in account the effective yield of the financial asset, which allocates interest over the relevant period.

NOTE 3: THE COST OF DELIVERY OUR SERVICES

This section provides an account of the expenses incurred by the hospital in delivering services and outputs. In Note 2, the funds that enable the provision of services were disclosed and in this note the cost associated with provision of services are recorded.

Structure

3.1 Expenses from Transactions
3.2 Other Economic Flows
3.3 Analysis of expense and revenue by internally managed and restricted specific purpose funds
3.4 Employee Benefits in the Balance Sheet
3.5 Superannuation

NOTE 3.1: EXPENSES FROM TRANSACTIONS

	Total 2019 $'000	Total 2018 $'000
Salaries and Wages	11,465	10,776
On-costs	1,239	1,138
Agency Expenses	24	19
Fee for Service Medical Officer Expenses	891	710
Workcover Premium	101	127
Total Employee Expenses	**13,720**	**12,770**
Drug Supplies	128	151
Medical and Surgical Supplies (including Prostheses)	411	414
Diagnostic and Radiology Supplies	100	110
Other Supplies and Consumables	439	506
Total Supplies and Consumables	**1,078**	**1,181**
Finance Costs – HRHA	7	3
Total Finance Costs	**7**	**3**
Fuel, Light, Power and Water	285	298
Repairs and Maintenance	204	201
Maintenance Contracts	105	56
Public Private Partnership Operating Expenses	310	273
Medical Indemnity Insurnace	192	200
Other Administrative Expenses	1,741	1,564
Expenditure for Capital Purposes	13	194
Total Other Operating Expenses	**2,850**	**2,786**
Depreciation and Amortisation (refer Note 4.4)	1,454	1,480
Total Other Non-Operating Expenses	**1,454**	**1,480**
Total Expenses from Transactions	**19,109**	**18,220**

Expenses are recognised as they are incurred and reported in the financial year to which they relate.

NOTE 3.1: EXPENSES FROM TRANSACTIONS (Continued)

Employee expenses
Employee expenses include:
- wages and salaries;
- leave entitlements;
- fringe benefits tax;
- workcover premiums;
- terminations payments; and
- superannuation expenses.

Supplies and consumables
Supplies and consumables – Supplies and services costs which are recognised as an expense in the reporting period in which they are incurred. The carrying amounts of any inventories held for distribution are expensed when distributed.

Finance Costs
Finance costs include:
- finance charges in respect of finance leases which are recognised in accordance with AASB 117 Leases.

Other operating expenses
Other operating expenses generally represent the day-to-day running costs incurred in normal operations and include such things as:
- Fuel, light and power
- Repairs and maintenance
- Other administrative expenses
- Expenditure for capital purposes (represents expenditure related to the purchase of assets that are below the capitalisation threshold).

The Department of Health and Human Services also makes certain payments on behalf of Mansfield District Hospital. These amounts have been brought to account as grants in determining the operating result for the year by recording them as revenue and also recording the related expense.

Non-operating expenses
Other non-operating expenses generally represent expenditure for outside the normal operations such as depreciation and amortisation, and assets and services provided free of charge or for nominal consideration.

NOTE 3.2: OTHER ECONOMIC FLOWS

	2019 $'000	2018 $'000
Net gain / (loss) on sale of non-financial assets		
Net gain on disposal of property plant and equipment	–	16
Total net gain / loss on non-financial assets	**–**	**16**
Other gains / (losses) from other economic flows		
Net gain / (loss) arising from revaluation of long service liability	(133)	(10)
Total other gains / (losses) from other economic flows	**(133)**	**(10)**
Total other gains / (losses) from economic flows	**(133)**	**6**

Other economic flows are changes in the volume or value of an asset or liability that do not result from transactions. Other gains/ (losses) from other economic flows include the gains or losses from:

- the revaluation of the present value of the long service leave liability due to changes in the bond interest rates.

Net gain / (loss) on non-financial assets

Net gain / (loss) on non-financial assets and liabilities includes realised and unrealised gains and losses as follows:

- Revaluation gain / (losses) of non-financial physical assets (Refer to Note 4.2 (f) Property plant and equipment)
- Net gain/(loss) on disposal of non-financial assets
- Any gain or loss on the disposal of non-financial assets is recognised at the date of disposal.

Other gains/ (losses) from other comprehensive income

Other gains/ (losses) include:

- the revaluation of the present value of the long service leave liability due to changes in the bond rate movements, inflation rate movements and the impact of changes in probability factors; and
- transfer of amounts from the reserves to accumulated surplus or net result due to disposal or derecognition or reclassification.

NOTE 3.3: ANALYSIS OF EXPENSE AND REVENUE BY INTERNALLY MANAGED AND RESTRICTED SPECIFIC PURPOSE FUNDS

	Expense		Revenue	
	2019 $'000	2018 $'000	**2019 $'000**	2018 $'000
Commercial Activities				
Diagnostic Imaging	79	88	105	108
Catering Services	38	33	80	68
Fundraising & Other	17	16	42	41
TOTAL	**134**	**137**	**227**	**217**

NOTE 3.4: EMPLOYEE BENEFITS IN THE BALANCE SHEET

	2019 $'000	2018 $'000
Current Provisions		
Employee Benefits (i)		
Accrued Days Off		
– unconditional and expected to be settled within 12 months (ii)	27	18
Annual Leave		
– unconditional and expected to be settled within 12 months (ii)	1,110	1,017
– unconditional and expected to be settled after 12 months (iii)	196	176
Long Service Leave (Note 3.4(a))		
–unconditional and expected to be settled within 12 months (ii)	191	171
– unconditional and expected to be settled after 12 months (iii)	1,385	1,095
Provisions Related to Employee Benefit On-Costs		
– unconditional and expected to be settled within 12 months (ii)	148	127
– unconditional and expected to be settled after 12 months (iii)	178	143
Total Current Provisions	3,235	2,747
Non-Current Provisions		
Long Service Leave (iii)	182	381
Provisions Related to Employee Benefit On-Costs	21	43
Total Non-Current Provisions	203	424
Total Provisions	3,438	3,171
(a) Employee Benefits and Related On-Costs		
Current Employee Benefits and related on-costs		
Annual Leave Entitlements	1,452	1,319
Accrued Salaries and Wages	–	–
Accrued Days Off	27	18
Unconditional Long Service Leave Entitlements	1,756	1,410
Non-Current Employee Benefits and Related On-Costs		
Conditional Long Service Leave Entitlements (iii)	203	424
Total Employee Benefits and Related On-Costs	3,438	3,171

Notes:
(i) Provisions for employee benefits consist of amounts for annual leave and long service leave accrued by employees, not including on-costs.
(ii) The amounts disclosed are nominal amounts.
(iii) The amounts disclosed are discounted to present values.

NOTE 3.4: EMPLOYEE BENEFITS IN THE BALANCE SHEET (Continued)

	2019 $'000	2018 $'000
(b) Movements in Provisions		
Movement in Long Service Leave:		
Balance at Start of Year	1,834	
Additional provisions recognised	151	
Unwinding of discount and effect of changes in the discount rate	133	
Reduction due to transfer out	(159)	
Balance at End of Year	**1,959**	

Employee Benefit Recognition
Provision is made for benefits accruing to employees in respect of annual leave, accrued days off and long service leave for services rendered to the reporting date as an expense during the period the services are delivered.

Provisions
Provisions are recognised when the Hospital has a present obligation, the future sacrifice of economic benefits is probable, and the amount of the provision can be measured reliably.

The amount recognised as a liability is the best estimate of the consideration required to settle the present obligation at reporting date, taking into account the risks and uncertainties surrounding the obligation.

Annual Leave and Accrued Days Off
Liabilities for annual leave and accrued days off are all recognised in the provision for employee benefits as 'current liabilities' because Mansfield District Hospital does not have an unconditional right to defer settlements of these liabilities.

Depending on the expectation of the timing of settlement, liabilities for salaries and wages, annual leave and accrued days off are measured at:

Nominal value – if the hospital expects to wholly settle within 12 months; or
Present value – if the hospital does not expect to wholly settle within 12 months.

Long Service Leave (LSL)
Liability for LSL is recognised in the provision for employee benefits.

Unconditional LSL is disclosed in the notes to the financial statements as a current liability, even where the hospital does not expect to settle the liability within 12 months because it will not have the unconditional right to defer the settlement of the entitlement should an employee take leave within 12 months. An unconditional right arises after a qualifying period.

The components of this current LSL liability are measured at:

Nominal value – if the hospital expects to wholly settle within 12 months; and
Present value – if the hospital does not expect to wholly settle within 12 months.

Conditional LSL is disclosed as a non-current liability. Any gain or loss followed revaluation of the present value of non-current LSL liability is recognised as a transaction, except to the extent that a gain or loss arises due to changes in estimations e.g. bond rate movements, inflation rate movements and changes in probability factors which are then recognised as other economic flows.

Termination Benefits
Termination benefits are payable when employment is terminated before the normal retirement date or when an employee decides to accept an offer of benefits in exchange for the termination of employment.

On-costs Related to Employee Expense
Provisions for on-costs, such as workers compensation and superannuation are recognised separately from the provision for employee benefits.

NOTE 3.5: SUPERANNUATION

		Paid Contributions for the Year		Contributions Outstanding at the Year End	
Fund		**2019 $'000**	2018 $'000	**2019 $'000**	2018 $'000
Defined Benefit Plans: [i]	Health Super	1	13	–	–
Defined Contribution Plans:	Health Super	502	497	–	–
	HESTA	467	456	–	–
	Other	78	19	–	–
Total		**1,048**	**985**	**–**	**–**

(i) The basis for determining the level of contributions is determined by the various actuaries of the defined benefit superannuation plans.

Employees of the hospital are entitled to receive superannuation benefits and the hospital contributes to both defined benefit and defined contribution plans. The defined benefit plan(s) provides benefits based on years of service and final average salary.

Defined Benefit Superannuation Plans
The Hospital does not recognise any unfunded defined benefit liability in respect of the plans because the entity has no legal or constructive obligation to pay future benefits relating to its employees; its only obligation is to pay superannuation contributions as they fall due. The Department of Treasury and Finance discloses the State's defined benefits liabilities in this disclosure for administered items.

However, superannuation contributions paid or payable for the reporting period are included as part of employee benefits in the comprehensive operating statement of Mansfield District Hospital.

The name, details and amounts expense in relation to the major employee superannuation funds and contributions made by the hospitals are disclosed in the table above.

Defined Contribution Superannuation Plans
In relation to defined contributions (i.e. accumulation) superannuation plans, the associated expense is simply the employer contributions that are paid or payable in respect of employees who are members of these plans during the reporting period.

Contributions to defined contribution superannuation plans are expensed when incurred.

NOTE 4: KEY ASSETS TO SUPPORT SERVICE DELIVERY

The hospital controls infrastructure and other investments that are utilised in fulfilling its objectives and conducting its activities. They represent the key resources that have been entrusted to the hospital to be utilised for delivery of those outputs.

Structure

4.1 Investments and other financial assets
4.2 Property, plant & equipment
4.3 Intangible assets
4.4 Depreciation and amortisation

NOTE 4.1: INVESTMENTS AND OTHER FINANCIAL ASSETS

	Spedific Purpose Fund		Capital Fund		Total	
	2019 $'000	2018 $'000	**2019 $'000**	2018 $'000	**2019 $'000**	2018 $'000
CURRENT						
Loans and Receivables						
Term Deposits > 3 months	–	12,176	–	5,561	–	17,737
TOTAL CURRENT	**–**	**12,176**	**–**	**5,561**	**–**	**17,737**
Represented by:						
Hospital Investments	–	–	–	5,561	–	5,561
Monies Held in Trust – Accommodation Bonds (Refundable Accommodation Deposits) (Note 5.3)	–	12,176	–	–	–	12,176
TOTAL	**–**	**12,176**	**–**	**5,561**	**–**	**17,737**

Investment Recognition
Investments are recognised and derecognised on trade date where purchase or sale of an investment is under a contract whose terms require delivery of the investment within the timeframe established by the market concerned, and are initially measured at fair value, net of transaction costs.

Investments are classified as loans and receivables or available-for-sale financial assets.

Mansfield District Hospital classifies its other financial assets between current and non-current assets based on the Board's intention at balance date with respect to the timing of disposal of each asset.

Mansfield District Hospital assesses at each balance sheet date whether a financial asset or group of financial assets is impaired.

The hospital's investments must comply with Standing Direction 3.7.2 – Treasury Management, including Central Banking System.

All financial assets, except those measured at fair value through profit and loss are subject to annual review for impairment.

Derecognition of Financial Assets
A financial asset (or, where applicable, a part of a financial asset or part of a group of similar financial assets) is derecognised when:
- the rights to receive cash flows from the asset have expired; or
- the hospital retains the right to receive cash flows from the asset, but has assumed an obligation to pay them in full without material delay to a third party under a 'pass through' arrangement; or
- the hospital has transferred its rights to receive cash flows from the asset and either:
  (a) has transferred substantially all the risks and rewards of the asset; or
  (b) has neither transferred nor retained substantially all the risks and rewards of the asset, but has transferred control of the asset.

Where the hospital has neither transferred nor retained substantially all the risks and rewards or transferred control, the asset is recognised to the extent of the hospital's continuing involvement in the asset.

Impairment of Financial Assets
At the end of each reporting period, Mansfield District Hospital assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. All financial instrument assets, except those measured at fair value through the Comprehensive Income Statement, are subject to annual review for impairment.

The above valuation process was used to quantify the level of impairment (if any) on the portfolio of financial assets as at year end.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT

Initial Recognition
Items of property, plant and equipment are measured initially at cost and subsequently revalued at fair value less accumulated depreciation and impairment loss. Where an asset is acquired for no or nominal cost, the cost is its fair value at the date of acquisition. Assets transferred as part of a merger/machinery of government change are transferred at their carrying amounts.

The cost of a leasehold improvement is capitalised as an asset and depreciated over the shorter of the remaining term of the lease or the estimated useful life of the improvements.

The initial cost for non-financial physical assets under finance lease (refer to Note 6.1) is measured at amounts equal to the fair value of the leased asset or, if lower, the present value of the minimum lease payments, each determined at the inception of the lease.

Theoretical opportunities that may be available in relation to the asset(s) are not taken into account until it is virtually certain that any restrictions will no longer apply. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best uses.

Land and buildings are recognised initially at cost and subsequently measured at fair value less accumulated depreciation and accumulated impairment loss.

Revaluations of Non-Current Physical Assets
Non-current physical assets are measured at fair value and are revalued in accordance with FRD 103H Non-Current Physical Assets. This revaluation process normally occurs every five years, based upon the asset's Government Purpose Classification, but may occur more frequently if fair value assessments indicate material changes in values. Independent valuers are used to conduct these scheduled revaluations and any interim revaluations are determined in accordance with the requirements of the FRDs. Revaluation increments or decrements arise from differences between an asset's carrying value and fair value.

Revaluation increments are recognised in 'Other Comprehensive Income' and are credited directly to the asset revaluation surplus, except that, to the extent that an increment reverses a revaluation decrement in respect of that same class of asset previously recognised as an expense in net result, the increment is recognised as income in the net result.

Revaluation decrements are recognised in 'Other Comprehensive Income' to the extent that a credit balance exists in the asset revaluation surplus in respect of the same class of property, plant and equipment.

Revaluation increases and revaluation decreases relating to individual assets within an asset class are offset against one another within that class but are not offset in respect of assets in different classes.

Revaluation surplus is not transferred to accumulated funds on de-recognition of the relevant asset, except where an asset is transferred via contributed capital.

In accordance with FRD 103H, Mansfield District Hospital's non-current physical assets were assessed to determine whether revaluation of the non-current physical assets was required.

Fair value measurement
Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date.

For the purpose of fair value disclosures, hospital has determined classes of assets on the basis of the nature, characteristics and risks of the asset and the level of the fair value hierarchy as explained above.

In addition, Mansfield District Hospital determines whether transfers have occurred between levels in the hierarchy by reassessing categorisation (based on the lowest level input that is significant to the fair value measurement as a whole) at the end of each reporting period.

The Valuer-General Victoria (VGV) is hospital's independent valuation agency.

The estimates and underlying assumptions are reviewed on an ongoing basis.

Valuation hierarchy
In determining fair values a number of inputs are used. To increase consistency and comparability in the financial statements, these inputs are categorised into three levels, also known as the fair value hierarchy. The levels are as follows:

- Level 1 – quoted (unadjusted) market prices in active markets for identical assets or liabilities;
- Level 2 – valuation techniques for which the lowest level input that is significant to the fair value measurement is directly or indirectly observable; and
- Level 3 – valuation techniques for which the lowest level input that is significant to the fair value measurement is unobservable.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

Identifying unobservable inputs (level 3) fair value measurements
Level 3 fair value inputs are unobservable valuation inputs for an asset or liability. These inputs require significant judgement and assumptions in deriving fair value for both financial and non-financial assets.

Unobservable inputs shall be used to measure fair value to the extent that relevant observable inputs are not available, thereby allowing for situations in which there is little, if any, market activity for the asset or liability at the measurement date. However, the fair value measurement objective remains the same, i.e., an exit price at the measurement date from the perspective of a market participant that holds the asset or owes the liability. Therefore, unobservable inputs shall reflect the assumptions that market participants would use when pricing the asset or liability, including assumptions about risk.

Consideration of highest and best use (HBU) for non-financial physical assets
Judgements about highest and best use must take into account the characteristics of the assets concerned, including restrictions on the use and disposal of assets arising from the asset's physical nature and any applicable legislative/contractual arrangements.

In accordance with paragraph AASB 13.29, hospitals can assume the current use of a non-financial physical asset is its HBU unless market or other factors suggest that a different use by market participants would maximise the value of the asset.

Specialised Land and Specialised Buildings
Specialised land includes Crown Land which is measured at fair value with regard to the property's highest and best use after due consideration is made for any legal or physical restrictions imposed on the asset, public announcements or commitments made in relation to the intended use of the asset. Theoretical opportunities that may be available in relation to the assets are not taken into account until it is virtually certain that any restrictions will no longer apply. Therefore, unless otherwise disclosed, the current use of these non-financial physical assets will be their highest and best use.

During the reporting period, Mansfield District Hospital held Crown Land. The nature of this asset means that there are certain limitations and restrictions imposed on its use and/or disposal that may impact their fair value.

The market approach is also used for specialised land and specialised buildings although it is adjusted for the community service obligation (CSO) to reflect the specialised nature of the assets being valued. Specialised assets contain significant, unobservable adjustments; therefore these assets are classified as Level 3 under the market based direct comparison approach.

The CSO adjustment is a reflection of the valuer's assessment of the impact of restrictions associated with an asset to the extent that is also equally applicable to market participants. This approach is in light of the highest and best use consideration required for fair value measurement, and takes into account the use of the asset that is physically possible, legally permissible and financially feasible. As adjustments of CSO are considered as significant unobservable inputs, specialised land would be classified as Level 3 assets.

For Mansfield District Hospital, the depreciated replacement cost method is used for the majority of specialised buildings, adjusting for the associated depreciation. As depreciation adjustments are considered as significant and unobservable inputs in nature, specialised buildings are classified as Level 3 for fair value measurements.

An independent valuation of Mansfield District Hospital's specialised land and specialised buildings was performed by the Valuer-General Victoria. The valuation was performed using the market approach adjusted for CSO. The effective date of the valuation is 30 June 2019.

Vehicles
The Hospital acquires new vehicles and at times disposes of them before completion of their economic life. The process of acquisition, use and disposal in the market is managed by the hospital who set relevant depreciation rates during use to reflect the consumption of the vehicles. As a result, the fair value of vehicles does not differ materially from the carrying amount (depreciated cost).

Plant and Equipment
Plant and equipment (including medical equipment, computers and communication equipment and furniture and fittings are held at carrying amount (depreciated cost). When plant and equipment is specialised in use, such that it is rarely sold other than as part of a going concern, the depreciated replacement cost is used to estimate the fair value. Unless there is market evidence that current replacement costs are significantly different from the original acquisition cost, it is considered unlikely that depreciated replacement cost will be materially different from the existing carrying amount.

There were no changes in valuation techniques throughout the period to 30 June 2019.

For all assets measured at fair value, the current use is considered the highest and best use.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

(a) Gross Carrying Amount and Accumulated Depreciation

	2019 $'000	2018 $'000
Land		
Land at Fair Value		
Crown	615	551
Freehold	1,430	1,848
Total Land	**2,045**	**2,399**
Landscaping Improvements at Fair Value	493	362
Less Accumulated Depreciation	–	(67)
	493	**295**
Buildings		
Buildings at Fair Value	22,727	19,168
Less Accumulated Depreciation	–	(4,061)
	22,727	**15,107**
Buildings & Plant Under Construction at Cost	28	1
Total Buildings	**22,755**	**15,108**
Plant and Equipment		
Plant and Equipment – Hume Rural Health Alliance	44	46
Plant and Equipment at Fair Value	2,353	2,196
Less Accumulated Depreciation	(1,779)	(1,683)
Total Plant and Equipment	**618**	**559**
Motor Vehicles		
Motor Vehicles at Fair Value	435	408
Less Accumulated Depreciation	(242)	(177)
Total Motor Vehicles	**193**	**231**
Medical Equipment		
Medical Equipment at Fair Value	2,142	1,933
Less Accumulated Depreciation	(1,511)	(1,380)
Total Medical Equipment	**631**	**553**
Computers and Communication		
Computers and Communication at Fair Value	31	31
Less Accumulated Depreciation	(10)	(7)
Total Computers and Communication	**21**	**24**
Furniture and Fittings		
Furniture and Fittings at Fair Value	550	520
Less Accumulated Depreciation	(380)	(345)
Total Furniture and Fittings	**170**	**175**
TOTAL PROPERTY, PLANT AND EQUIPMENT	**26,926**	**19,344**

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

(b) Reconciliation of the Carrying Amounts of Each Class of Asset

	Land	Land Improvements	WIP – Buildings & Plant	Buildings	Plant and Equipment	Medical Equipment	Computers & Commun.	Furniture & Fittings	Motor Vehicles	Total
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Balance at 1 July 2017	**2,399**	**312**	**2**	**16,134**	**646**	**602**	**4**	**172**	**243**	**20,514**
Additions	–	–	38	1	41	85	25	42	65	297
Hume Rural Health Alliance Assets	–	–	–	–	23	–	–	–	–	23
Contributions	–	–	–	–	–	(3)	–	–	–	(3)
Disposals	–	–	–	–	–	–	–	–	(9)	(9)
Net Transfer Between Classes	–	–	(39)	39	–	–	–	–	–	–
Depreciation (refer Note 4.4)	–	(17)	–	(1,067)	(151)	(131)	(5)	(39)	(68)	(1,478)
Balance at 30 June 2018	**2,399**	**295**	**1**	**15,107**	**559**	**553**	**24**	**175**	**231**	**19,344**
Additions	–	–	179	–	188	209	–	30	27	633
Revaluation increaments /(decrements)	(354)	215	–	8,535	2	–	–	–	–	8,398
Net Transfers between Classes	–	–	(152)	152	–	–	–	–	–	–
Depreciation (refer Note 4.4)	–	(17)	–	(1,067)	(131)	(131)	(3)	(35)	(65)	(1,449)
Balance at 30 June 2019	**2,045**	**493**	**28**	**22,727**	**618**	**631**	**21**	**170**	**193**	**26,926**

Land and Buildings Carried at Valuation

The Valuer-General Victoria undertook to re-value all of Mansfield District Hospital owned land and buildings to determine their fair value. The valuation, which conforms to Australian Valuation Standards, was determined by reference to the amounts for which assets could be exchanged between knowledgeable willing parties in an arm's length transaction. The valuation was based on independent assessments. The effective date of the valuation is 30 June 2019.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

(c) Fair Value Measurement Hierarchy for Assets as at 30 June 2019

	Carrying Amount as at 30 June 2019 $'000	Fair Value Measurement at End of Reporting Period Using: Level 1(i) $'000	Level 2(i) $'000	Level 3(i) $'000
Land at Fair Value				
Specialised Land	2,045	–	–	2,045
Total Land at Fair Value	2,045	–	–	2,045
Land Improvements at Fair Value				
Land Improvements	493	–	–	493
Total Land Improvements at Fair Value	493	–	–	493
Buildings at Fair Value				
Specialised Buildings	22,727	–	–	22,727
Total Buildings at Fair Value	22,727	–	–	22,727
Plant and Equipment at Fair Value				
Plant and Equipment at Fair Value	618	–	–	618
Total Plant and Equipment at Fair Value	618	–	–	618
Medical Equipment at Fair Value				
Medical Equipment at Fair Value	631	–	–	631
Total Medical Equipment at Fair Value	631	–	–	631
Computers & Communication at Fair Value				
Computers and Communication at Fair Value	21	–	–	21
Total Computers and Communication at Fair Value	21	–	–	21
Furniture & Fittings at Fair Value				
Furniture & Fittings at Fair Value	170	–	–	170
Total Furniture & Fittings at Fair Value	170	–	–	170
Motor Vehicles at Fair Value				
Motor Vehicles at Fair Value	193	–	193	–
Total Motor Vehicles at Fair Value	193	–	193	–
Total Property, Plant and Equipment	**26,898**	**–**	**193**	**26,705**

Note:
(i) Classified in accordance with the fair value hierarchy.
(ii) There have been no transfers between levels during the period.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

(c) Fair value measurement hierarchy for assets as at 30 June 2018

	Carrying amount as at 30 June 2018 $'000	Fair value measurement at end of reporting period using: Level 1(i) $'000	Level 2(i) $'000	Level 3(i) $'000
Land at Fair Value				
Specialised Land	2,399	–	–	2,399
Total Land at Fair Value	2,399	–	–	2,399
Land Improvements at Fair Value				
Land Improvements	295	–	–	295
Total Land Improvements at Fair Value	295	–	–	295
Buildings at Fair Value				
Specialised Buildings	15,107	–	–	15,107
Total Buildings at Fair Value	15,107	–	–	15,107
Plant and Equipment at Fair Value				
Plant and Equipment at Fair Value	559	–	–	559
Total Plant and Equipment at Fair Value	559	–	–	559
Medical Equipment at Fair Value				
Medical Equipment at Fair Value	553	–	–	553
Total Medical Equipment at Fair Value	553	–	–	553
Computers & Communication at Fair Value				
Computers and Communication at Fair Value	24	–	–	24
Total Computers and Communication at Fair Value	24	–	–	24
Furniture & Fittings at Fair Value				
Furniture & Fittings at Fair Value	175	–	–	175
Total Furniture & Fittings at Fair Value	175	–	–	175
Motor Vehicles at Fair Value				
Motor Vehicles at Fair Value	231	–	231	–
Total Motor Vehicles at Fair Value	231	–	231	–
Total Property, Plant and Equipment	**19,343**	**–**	**231**	**19,112**

Note:
(i) Classified in accordance with the fair value hierarchy.
(ii) There have been no transfers between levels during the period.

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

(d) Reconciliation of Level 3 Fair Value as at 30 June 2019

	Land $'000	Land Improvements $'000	Buildings $'000	Plant and Equipment $'000	Medical Equipment $'000	Computers & Commun. $'000	Furniture & Fittings $'000
Balance as at 1 July 2018	2,399	295	15,107	559	553	24	175
Additions / (Disposals)	–	–	152	188	209	–	30
Gains or Losses Recognised in Net Result – Depreciation	–	(17)	(1,067)	(131)	(131)	(3)	(35)
Items Recognised in Other Comprehensive Income – Revaluation	(354)	215	8,535	2	–	–	–
Balance as at 30 June 2019	**2,045**	**493**	**22,727**	**618**	**631**	**21**	**170**

Reconciliation of Level 3 Fair Value as at 30 June 2018

	Land $'000	Land Improvements $'000	Buildings $'000	Plant and Equipment $'000	Medical Equipment $'000	Computers & Commun. $'000	Furniture & Fittings $'000
Balance as at 1 July 2017	2,399	312	16,134	646	602	4	172
Additions / (Disposals)	–	–	1	65	82	25	43
Transfers Between Classes	–	–	38	–	–	–	–
Gains or Losses Recognised in Net Result – Depreciation	–	(17)	(1,067)	(151)	(131)	(5)	(39)
Items Recognised in Other Comprehensive Income – Revaluation	–	–	–	–	–	–	–
Balance as at 30 June 2018	**2,399**	**295**	**15,107**	**559**	**553**	**24**	**175**

(i) Classified in accordance with the fair value hierarchy, refer Note 4.2(c).

NOTE 4.2: PROPERTY, PLANT AND EQUIPMENT (Continued)

(e) Fair Value determination

Asset Class	Likely Valuation Approach	Significant inputs (Level 3 only)
Specialised land	Market approach	– Community service obligation adjustments – CSO adjustment of 20% was applied
Specialised buildings	Depreciated replacement cost approach	– Cost per square metre – Useful life
Plant and equipment	Depreciated replacement cost approach	– Cost per unit – Useful life
Computers and Furniture	Depreciated replacement cost approach	– Cost per unit – Useful life
Medical equipment at fair value	Depreciated replacement cost approach	– Cost per unit – Useful life
Motor Vehicles	Market approach	n.a.

(f) Property, Plant and Equipment Revaluation Surplus

	2019 $'000	2018 $'000
Property, Plant and Equipment Revaluation Surplus		
Balance at the beginning of the reporting period	16,703	16,703
Revaluation Increment		
– Land	(354)	–
– Land Improvements	215	–
– Buildings	8,537	–
Balance at the end of the reporting period *	**25,101**	**16,703**
* Represented by :		
– Land	1,333	1,687
– Land Improvements	215	–
– Buildings	23,553	15,016
	25,101	**16,703**

NOTE 4.3: INTANGIBLE ASSETS

(a) Gross carrying amount and accumulated amortisation

	2019 $'000	2018 $'000
Intangible Produced Assets – HRHA	36	27
Less Accumulated Depreciation	(13)	(8)
TOTAL INTANGIBLE ASSETS	**23**	**19**

(b) Reconciliation of the carrying amount by class of asset	**HRHA**	**Total**
Balance as at 1 July 2017	**64**	**64**
Additions	(43)	(43)
Depreciation and Amortisation (refer Note 4.4)	(2)	(2)
Balance as at 1 July 2018	**19**	**19**
Additions	9	9
Depreciation and Amortisation (refer Note 4.4)	(5)	(5)
Balance as at 30 June 2019	**23**	**23**

Intangible assets represent identifiable non-monetary assets without physical substance such as computer software.

Intangible assets are initially recognised at cost. Subsequently, intangible assets with finite useful lives are carried at cost less accumulated amortisation and accumulated impairment losses. Costs incurred subsequent to initial acquisition are capitalised when it is expected that additional future economic benefits will flow to Mansfield District Hospital.

NOTE 4.4: DEPRECIATION AND AMORTISATION

	2019 $'000	2018 $'000
Depreciation		
Buildings	1,067	1,067
Land Improvements	17	17
Plant and Equipment		
– Plant	115	126
– Motor Vehicles	65	68
Computers and Communication	3	5
Medical Equipment	131	131
Furniture and Fittings	35	39
Hume Rural Health Alliance	16	25
Total Depreciation	1,449	1,478
Amortisation		
Intangible Assets (HRHA)	5	2
Total Amortisation	5	2
Total Depreciation and Amortisation	**1,454**	**1,480**

Depreciation and amortisation recognition
Depreciation
All infrastructure assets, buildings, plant and equipment and other non-financial physical assets (excluding items under operating leases and land) that have finite useful lives are depreciated. Depreciation is generally calculated on a straight-line basis at rates that allocate the asset's value, less any estimated residual value over its estimated useful life (refer AASB 116 Property, Plant and Equipment).

Amortisation
Amortisation is the systematic allocation of the depreciable amount of an asset over its useful life. The following table indicates the expected useful lives of non-current assets on which the depreciation charges are based:

	2019	2018
Buildings		
– Structure Shell Building Fabric	10 to 40 years	10 to 40 years
– Landscaping	10 to 40 years	10 to 40 years
– Site Engineering Services and Central Plant	10 to 40 years	10 to 40 years
Central Plant		
– Fit Out	10 to 40 years	10 to 40 years
– Trunk Reticulated Building Systems	10 to 40 years	10 to 40 years
Plant and Equipment	3 to 20 years	3 to 20 years
Medical Equipment	3 to 20 years	3 to 20 years
Computers and Communication	3 to 4 years	3 to 4 years
Furniture and Fittings	5 to 10 years	5 to 10 years
Motor Vehicles	4 to 10 years	4 to 10 years

As part of the buildings valuation, building values were separated into components and each component assessed for its useful life which is represented above.

NOTE 5: OTHER ASSETS AND LIABILITIES

This section sets out those assets and liabilities that arose from the hospital's operations.

Structure

5.1 Receivables
5.2 Payables
5.3 Other liabilities

NOTE 5.1: RECEIVABLES

	2019 $'000	2018 $'000
CURRENT		
Contractual		
Trade Debtors	93	186
Patient and Resident Fees	192	136
Accrued Investment Income	–	106
Accrued Revenue – Other	10	37
Hume Rural Health Alliance – Other Receivables	52	153
Less Allowance for impairment losses of contractual receivables		
Patient and Resident Fees	(15)	(24)
	332	**594**
Statutory		
GST Receivable	77	73
Accrued Revenue – Department of Health and Human Services	10	–
Department of Health & Ageing – Commonwealth	–	15
	87	**88**
TOTAL CURRENT RECEIVABLES	**419**	**682**
NON CURRENT		
Statutory		
Long Service Leave – Department of Health and Human Services	686	802
TOTAL NON-CURRENT RECEIVABLES	**686**	**802**
TOTAL RECEIVABLES	**1,105**	**1,484**

	2019 $'000	2018 $'000
(a) Movement in the Allowance for impairment losses of contractual receivables		
Balance at beginning of year	20	18
Increase/(Decrease) in Allowance Recognised in Net Result	(5)	2
Balance at End of Year	**15**	**20**

Receivables recognition
Receivables consist of:

- Contractual receivables, which consists of mainly debtors in relation to goods and services and accrued investment income. These receivables are classified as financial instruments and categorised as 'financial assets at amortised costs'. They are initially recognised at fair value plus any directly attributable transaction costs. Mansfield District Hospital holds the contractual receivables with the objective to collect the contractual cash flows and therefore subsequently measured at amortised cost using the effective interest method, less any impairment.
- Statutory receivables, which includes predominantly amounts owing from the Victorian Government and Goods and Services Tax (GST) input tax credits recoverable. Statutory receivables do not arise from contracts and are recognised and measured similarly to contractual receivables (except for impairment), but are not classified as financial instruments for disclosure purposes. Mansfield District Hospital applies AASB 9 for initial measurement of the statutory receivables and as a result statutory receivables are initially recognised at fair value plus any directly attributable transaction cost.

Trade debtors are carried at nominal amounts due and are due for settlement within 30 days from the date of recognition.

In assessing impairment of statutory (non-contractual) financial assets, which are not financial instruments, professional judgement is applied in assessing materiality using estimates, averages and other computational methods in accordance with AASB 136 Impairment of Assets.

Mansfield District Hospital is not exposed to any significant credit risk exposure to any single counterparty or any group of counterparties having similar characteristics. Trade receivables consist of a large number of customers in various geographical areas. Based on historical information about customer default rates, management consider the credit quality of trade receivables that are not past due or impaired to be good.

Receivables are subject to impairment loss assessment in accordance with AASB 9's expected credit loss model and the impairment loss allowance is increased accordingly with the impairment expense recognised in the net result as an 'other economic flow'. However, when it becomes mutually agreed between debtor and creditor that the receivable has become uncollectible, the carrying amount of the receivable needs to be reduced, and a bad debt expense for the write-off recognised in the net result as a transaction. Accordingly at the same time, the amount in the provision together with its related impairment expense initially recognised as an 'other economic flow' will need to be reversed.

Impairment losses of contractual receivables
Refer to Note 7.1 (c) Contractual receivables at amortised costs for Mansfield District Hospital's contractual impairment losses.

NOTE 5.2: PAYABLES

	2019 $'000	2018 $'000
CURRENT		
Contractual		
Trade Creditors	377	244
Accrued Salaries and Wages	257	203
Accrued Expenses	127	132
Hume Rural Health Alliance Payables	145	197
Income in Advance	–	288
	906	**1,064**
Statutory		
GST Payable	30	31
Department of Health and Human Services	88	219
	118	**250**
TOTAL CURRENT	**1,024**	**1,314**
TOTAL PAYABLES	**1,024**	**1,314**

Payables Recognition
Payables consist of:

- Contractual payables which consist predominantly of accounts payable representing liabilities for goods and services provided to the Health Service prior to the end of the financial year that are unpaid, and arise when the Health Service becomes obliged to make future payments in respect of the purchase of those goods and services. The normal credit terms for accounts payable are usually Net 30 days.
- Statutory payables, that are recognised and measured similarly to contractual payables, but are not classified as financial instruments and not included in the category of financial liabilities at amortised cost, because they do not arise from contracts

Maturity analysis of payables
Please refer to Note 7.1(b) for the ageing analysis of payables.

NOTE 5.3: OTHER LIABILITIES

	2019 $'000	2018 $'000
CURRENT		
Monies Held in Trust*		
– Accommodation Bonds (Refundable Entrance Fees)	12,012	12,176
TOTAL CURRENT	**12,012**	**12,176**
*** Total Monies Held in Trust**		
Represented by the following assets:		
Cash Assets	12,012	12,176
TOTAL	**12,012**	**12,176**

NOTE 6: HOW WE FINANCE OUR OPERATIONS

This section provides information on the sources of finance utilised by the hospital during its operations, along with interest expenses (the cost of borrowings) and other information related to financing activities of the hospital.

This section includes disclosures of balances that are financial instruments (such as borrowings and cash balances).
Note: 7.1 provides additional, specific financial instrument disclosures.

Structure

6.1 Borrowings
6.2 Cash and cash equivalents
6.3 Commitments for expenditure

NOTE 6.1: BORROWINGS

	2019 $'000	2018 $'000
CURRENT		
Lease Liabilities		
– Hume Rural Health Alliance Finance Lease Liability (i)	16	17
Total Current	16	17
NON CURRENT		
Lease Liabilities		
– Hume Rural Health Alliance Finance Lease Liability (i)	13	17
Total Non Current	**13**	**17**
TOTAL LEASE LIABILITIES	**29**	**34**

(i) Secured by the assets leased. Finance leases are effectively secured as the rights to the leased assets revert to the lessor in the event of default.

Maturity Analysis of Borrowings
Please refer to note 7.1 (b) for the ageing analysis of borrowings.

Defaults and Breaches
During the current and prior year, there were no defaults and breaches of any of the borrowings.

Finance Lease Liabilities
HRHA lease liabilities

	Minimum future lease payments (i)		Present value of minimum future lease payments	
	2019 $'000	2018 $'000	2019 $'000	2018 $'000
HRHA finance lease liabiliities payable (ii)				
Not longer than one year	17	18	16	17
Longer than one year but not longer than five years	14	18	13	17
Minimum future lease payments	31	36	29	34
Less future finance charges	(2)	(2)	–	–
Present value of minimum lease payments	29	34	29	34
Included in the financial statements as:				
Current lease liabilities	16	17	16	17
Non Current lease liabilities	13	17	13	17
TOTAL	**29**	**34**	**29**	**34**

(i) Minimum future lease payments include the aggregate of all base payments and any guaranteed residual.
(ii) HRHA finance lease liabilities include obligations that are recognised on the balance sheet.

Borrowing Recognition
A lease is a right to use an asset for an agreed period of time in exchange for payment. Leases are classified at their inception as either operating or finance leases based on the economic substance of the agreement so as to reflect the risks and rewards incidental to ownership.

Leases of property, plant and equipment are classified as finance leases whenever the terms of the lease transfer substantially all the risks and rewards of ownership to the lessee.

All other leases are classified as operating leases.

Finance leases
Entity as lessee
Finance leases are recognised as assets and liabilities at amounts equal to the fair value of the lease property or, if lower, the present value of the minimum lease payment, each determined at the inception of the lease.

Minimum lease payments are apportioned between reduction of the outstanding lease liability, and the periodic finance expense which is calculated using the interest rate implicit in the lease, and charged directly to the Comprehensive Operating Statement. Contingent rentals associated with finance leases are recognised as an expense in the period in which they are incurred.

NOTE 6.2: CASH AND CASH EQUIVALENTS

	2019 $'000	2018 $'000
Cash on Hand (excluding Monies held in trust)	1	1
Cash at Bank (excluding Monies held in trust)	8,286	1,116
Cash at Bank (Monies held in trust)	12,012	–
TOTAL CASH AND CASH EQUIVALENTS	**20,299**	**1,117**

Cash and cash equivalents recognised on the balance sheet comprise cash on hand and cash at bank, deposits at call and highly liquid investments (with an original maturity of three months or less), which are held for the purpose of meeting short term cash commitments rather than for investment purposes, which are readily convertible to known amounts of cash and are subject to insignificant risk of changes in value.

The cash flow statement includes monies held in trust.

NOTE 6.3: COMMITMENTS FOR EXPENDITURE

	2019 $'000	2018 $'000
Operating Commitments		
Information and Communication Technology Services	61	56
Total Operating Commitments (Inclusive of GST)	**61**	**56**
Operating Commitments Payable		
Not later than one year	35	32
Later than 1 and not later than 5 years	26	24
Total Operating Commitments (Inclusive of GST)	**61**	**56**
Total Commitments (Inclusive of GST)	61	93
Less GST recoverable from Australian Tax Office	6	8
Total Commitments (exclusive of GST)	**55**	**85**

Future finance lease payments are recognised on the balance sheet, refer to Note 6.1 Borrowings.

All amounts shown in the commitments note are nominal amounts inclusive of GST.

Commitments for future expenditure include operating and capital commitments arising from contracts. These commitments are disclosed by way of a note at their nominal value and are inclusive of the GST payable. In addition, where it is considered appropriate and provides additional relevant information to users, the net present values of significant individual projects are sated. These future expenditures cease to be disclosed as commitments once the related liabilities are recognised on the balance sheet.

NOTE 7: RISKS, CONTINGENCIES AND VALUATION UNCERTAINTIES

Structure

NOTE 7.1: FINANCIAL INSTRUMENTS

Financial instruments arise out of contractual agreements that give rise to a financial asset of one entity and a financial liability or equity instrument of another entity. Due to the nature of Mansfield District Hospital's activities, certain financial assets and financial liabilities arise under statute rather than a contract. Such financial assets and financial liabilities do not meet the definition of financial instruments in AASB 132 Financial Instruments: Presentation.

(a) Financial instruments: categorisation

2019	Financial assets at amortised cost $'000	Financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets			
Cash and cash equivalents	20,299	–	20,299
Receivables			
– Trade Debtors	285	–	285
– Other Receivables	62	–	62
Other Financial Assets	–	–	–
Total Financial Assets (i)	**20,646**	**–**	**20,646**
Financial Liabilities			
Payables	–	906	906
Lease Liabilities	–	29	29
Other Financial Liabilities			
– Accommodation Bonds	–	12,012	12,012
Total Financial Liabilities (ii)	**–**	**12,947**	**12,947**

2018	Contractual financial assets – loans and receivables $'000	Contractual financial liabilities at amortised cost $'000	Total $'000
Contractual Financial Assets			
Cash and cash equivalents	1,117	–	1,117
Receivables			
– Trade Debtors	322	–	322
– Other Receivables	296	–	296
Other Financial Assets			
– Term Deposits	17,737	–	17,737
Total Financial Assets (i)	**19,472**	**–**	**19,472**
Financial Liabilities			
Payables	–	1,064	1,064
Lease Liabilities	–	34	34
Other Financial Liabilities			
– Accommodation Bonds	–	12,176	12,176
Total Financial Liabilities (ii)	**–**	**13,274**	**13,274**

(i) The carrying amount excludes statutory receivables (i.e. GST receivable and DHHS receivable) and statutory payables (i.e. Revenue in Advance and DHHS payable).

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

From 1 July 2018, Mansfield District Hospital applies AASB 9 and classifies all of its financial assets based on the business model for managing the assets and the asset's contractual terms.

Categories of financial assets under AASB 9

Financial assets at amortised cost
Financial assets are measured at amortised costs if both of the following criteria are met and the assets are not designated as fair value through net result:
- the assets are held by hospital to collect the contractual cash flows, and
- the assets' contractual terms give rise to cash flows that are solely payments of principal and interests.

These assets are initially recognised at fair value plus any directly attributable transaction costs and subsequently measured at amortised cost using the effective interest method less any impairment.

The hospital recognises the following assets in this category:
- cash and deposits;
- receivables (excluding statutory receivables); and
- term deposits.

Categories of financial assets previously under AASB 139

Loans and receivables and cash are financial instrument assets with fixed and determinable payments that are not quoted on an active market. These assets and liabilities are initially recognised at fair value plus any directly attributable transaction costs. Subsequent to initial measurement, loans and receivables are measured at amortised cost using the effective interest method (and for assets, less any impairment). Mansfield District Hospital recognises the following assets in this category:
- cash and deposits;
- receivables (excluding statutory receivables); and
- term deposits.

Financial liabilities at amortised cost are initially recognised on the date they are originated. They are initially measured at fair value plus any directly attributable transaction costs. Subsequent to initial recognition, these financial instruments are measured at amortised cost with any difference between the initial recognised amount and the redemption value being recognised in profit and loss over the period of the interest bearing liability, using the effective interest rate method. Hospital recognises the following liabilities in this category:
- payables (excluding statutory payables); and
- borrowings (including finance lease liabilities).

Derecognition of financial assets: A financial asset (or, where applicable, a part of a financial asset or part of a group of similar financial assets) is derecognised when the rights to receive cash flows from the asset have expired.

Derecognition of financial liabilities: A financial liability is derecognised when the obligation under the liability is discharged, cancelled or expires.

Impairment of financial assets: At the end of each reporting period, the hospital assesses whether there is objective evidence that a financial asset or group of financial assets is impaired. All financial instrument assets, except those measured at fair value through profit or loss, are subject to annual review for impairment.

The allowance is the difference between the financial asset's carrying amount and the present value of estimated future cash flows, discounted at the effective interest rate. In assessing impairment of statutory (non-contractual) financial assets, which are not financial instruments, professional judgement is applied in assessing materiality using estimates, averages and other computational methods in accordance with AASB 136 Impairment of Assets.

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

(b) Maturity analysis of Financial Liabilities as at 30 June

The following table discloses the contractual maturity analysis for Mansfield District Hospital's financial liabilities. For interest rates applicable to each class of liability refer to individual notes to the financial statements.

			Maturity Dates			
	Carrying Amount $'000	Nominal Amount $'000	Less than 1 Month $'000	1–3 Months $'000	3 Months – 1 Year $'000	1–5 Years $'000
2019						
Financial Liabilities						
Payables	906	906	906	–	–	–
Hume Rural Health Alliance Finance Lease Liability	29	29	2	5	9	13
Other Financial Liabilities (i)						
– Accommodation Bonds	12,012	12,012	240	480	2,283	9,009
Total Financial Liabilities	**12,947**	**12,947**	**1,148**	**485**	**2,292**	**9,022**
2018						
Financial Liabilities						
Payables	1,064	1,064	1,064	–	–	–
Hume Rural Health Alliance Finance Lease Liability	31	31	1	4	11	15
Other Financial Liabilities (i)						
– Accommodation Bonds	12,176	12,176	244	487	2,314	9,132
Total Financial Liabilities	**13,271**	**13,271**	**1,309**	**491**	**2,325**	**9,147**

(i) Ageing analysis of financial liabilities excludes the types of statutory financial liabilities (i.e. GST payable).

(c) Contractual receivables at amortised costs

1-Jul-18	Current	Less than 1 month	1–3 months	3 months – 1 year	1–5 years	Total
Expected loss rate	1%	2%	3%	10%	50%	
Gross carrying amount of contractual receivables ($'000)	388	46	32	152	–	618
Loss Allowance	**4**	**1**	**1**	**14**	**–**	**20**

1-Jul-19	Current	Less than 1 month	1–3 months	3 months – 1 year	1–5 years	Total
Expected loss rate	1%	2%	3%	10%	50%	
Gross carrying amount of contractual receivables ($'000)	193	26	18	110	–	347
Loss Allowance	**2**	**1**	**1**	**11**	**–**	**15**

Impairment of financial assets under AASB 9 – applicable from 1 July 2018
From 1 July 2018, the Mansfield District Hospital has been recording the allowance for expected credit loss for the relevant financial instruments, replacing AASB 139's incurred loss approach with AASB 9's Expected Credit Loss approach. Subject to AASB 9 impairment assessment include the hospital's contractual receivables, statutory receivables and its investment in debt instruments.

Equity instruments are not subject to impairment under AASB 9. Other financial assets mandatorily measured or designated at fair value through net result are not subject to impairment assessment under AASB 9. While cash and cash equivalents are also subject to the impairment requirements of AASB 9, the identified impairment loss was immaterial.

Contractual receivables at amortised cost
Mansfield District Hospital applies AASB 9 simplified approach for all contractual receivables to measure expected credit losses using a lifetime expected loss allowance based on the assumptions about risk of default and expected loss rates. The hospital has grouped contractual receivables on shared credit risk characteristics and days past due and select the expected credit loss rate based on the hospital's past history, existing market conditions, as well as forward looking estimates at the end of the financial year.

On this basis, the hospital determines the opening loss allowance on initial application date of AASB 9 and the closing loss allowance at end of the financial year as disclosed above.

NOTE 7.1: FINANCIAL INSTRUMENTS (Continued)

Reconciliation of the movement in the loss allowance for contractual receivables

	2019 $'000	2018 $'000
Balance at beginning of the year	20	18
Opening Loss Allowance	**20**	**18**
Increase in provision recognised in the net result	–	20
Reversal of provision of receivables written off druing the year as uncollectible	5	18
Balance at end of the year	**15**	**20**

Credit loss allowance is classified as other economic flows in the net result. Contractual receivables are written off when there is no reasonable expectation of recovery and impairment losses are classified as a transaction expense. Subsequent recoveries of amounts previously written off are credited against the same line item.

In prior years, a provision for doubtful debts is recognised when there is objective evidence that the debts may not be collected and bad debts are written off when identified. A provision is made for estimated irrecoverable amounts from the sale of goods when there is objective evidence that an individual receivable is impaired. Bad debts considered as written off by mutual consent

Statutory receivables and debt investments at amortised cost
The hospital's non-contractual receivables arising from statutory requirements are not financial instruments. However, they are nevertheless recognised and measured in accordance with AASB 9 requirements as if those receivables are financial instruments.

The statutory receivables are considered to have low credit risk, taking into account the counterparty's credit rating, risk of default and capacity to meet contractual cash flow obligations in the near term. As the result, the loss allowance recognised for these financial assets during the period was limited to 12 months expected losses. No loss allowance recognised at 30 June 2018 under AASB 139. No additional loss allowance required upon transition into AASB 9 on 1 July 2018.

NOTE 7.2: CONTINGENT ASSETS AND CONTINGENT LIABILIITES

There are no known contingent assets or liabilities for Mansfield District Hospital as at the date of this report (2018: NIL).

Contingent assets and contingent liabilities are not recognised in the balance sheet, but are disclosed by way of note and, if quantifiable, are measured at nominal value. Contingent assets and contingent liabilities are presented inclusive of GST receivable or payable respectively.

NOTE 8: OTHER DISCLOSURES

This section includes additional material disclosures required by accounting standards or otherwise, for the understanding of this financial report.

Structure

8.1 Reconciliation of net result for the year to net cash inflow/(outflow) from operating activities
8.2 Responsible persons
8.3 Remuneration of Executives
8.4 Related parties
8.5 Remuneration of auditors
8.6 Ex-gratia expenses
8.7 Events occurring after the balance sheet date
8.8 Jointly Controlled Operations
8.9 Economic Dependency
8.10 AASBs issued that are not yet effective

NOTE 8.1: RECONCILIATION OF NET RESULT FOR THE YEAR TO NET CASH INFLOW/ (OUTFLOW) FROM OPERATING ACTIVITIES

	2019 $'000	2018 $'000
NET RESULT FOR THE YEAR	453	48
Non-cash movements		
Depreciation and Amortisation	1,454	1,480
Impairment of Non-financial Assets – HRHA	–	(74)
Movements included in investing and financing activities		
Net (Gain)/Loss from Disposal of Plant and Equipment	–	(16)
Movements in assets and liabilities		
Change in Operating Assets & Liabilities		
(Increase)/Decrease in Receivables	379	(109)
(Increase)/Decrease in Prepayments	(6)	(83)
(Increase)/Decrease in Inventories	(1)	12
Increase/(Decrease) in Payables	(290)	483
Increase/(Decrease) in Provisions	267	202
NET CASH INFLOW/(OUTFLOW) FROM OPERATING ACTIVITIES	**2,256**	**1,943**

NOTE 8.2: RESPONSIBLE PERSON DISCLOSURES

(a) Responsible Persons

In accordance with the Ministerial Directions issued by the Assistant Treasurer under the Financial Management Act 1994, the following disclosures are made regarding responsible persons for the reporting period.

	Period
Responsible Ministers:	
The Honourable Jill Hennessy, Minister for Health, Minister for Ambulance Services.	01/07/2018 – 29/11/2018
The Honourable Jenny Mikakos, Minister for Health, Minister for Ambulance Services.	29/11/2018 – 30/06/2019
The Honourable Martin Foley, Minister for Mental Health.	01/07/2018 – 30/06/2019
The Honourable Martin Foley, Minister for Housing, Mionister for Disability and Ageing.	01/07/2018 – 29/11/2018
The Honourable Luke Donnellan, Minister for Child Protection, Minister for Disability, Ageing and Carers.	29/11/2018 – 30/06/2019
Governing Boards	
Mrs R. Adams	01/07/2018 – 30/06/2019
Mr M. Beattie	01/07/2018 – 30/06/2019
Mrs G. Belle	01/07/2018 – 30/06/2019
Assoc. Prof J. Freemantle	01/07/2018 – 30/06/2019
Mr P. Officer	01/07/2018 – 30/06/2019
Dr. P. Dalgliesh	01/07/2018 – 30/06/2019
Ms. K Lockey	01/07/2018 – 30/06/2019
Prof. B Happell	01/07/2018 – 30/06/2019
Mrs K Brkljacic	01/07/2018 – 03/12/2018
Ms. L Watters	01/07/2018 – 13/11/2018
Accountable Officers	
Cameron Butler (Chief Executive Officer)	01/07/2018 – 30/06/2019

Remuneration for Responsible Persons

The number of Responsible Persons are shown in their relevant income bands:

	Parent	
	2019 No.	2018 No.
$0 – $190,000	10	9
$190,000 – $199,999	1	1
Total Numbers	**11**	**10**
Total remuneration received or due and receivable by Responsible Persons from the reporting entity amounted to ($'000):	**244**	**206**

Amounts relating to Responsible Ministers are reported within the Department of Parliamentary Services' Financial Report.

NOTE 8.3: REMUNERATION OF EXECUTIVES

The number of executive officers, other than Ministers and Accountable Officers, and their total remuneration during the reporting period are shown in the table below. Total annualised employee equivalent provides a measure of full time equivalent executive officers over the reporting period.

Remuneration comprises employee benefits in all forms of consideration paid, payable or provided in exchange for services rendered, and is disclosed in the following categories:

Short-term Employee Benefits
Salaries and wages, annual leave or sick leave that are usually paid or payable on a regular basis, as well as non-monetary benefits such as allowances and free or subsidised goods or services.

Post-employment Benefits
Pensions and other retirement benefits paid or payable on a discrete basis when employment has ceased.

Other Long-term Benefits
Long service leave, other long-service benefit or deferred compensation.

Termination Benefits
Termination of employment payments, such as severance packages.

Total remuneration payable to executives during the year included additional executive officers and a number of executives who received bonus payments during the year. These bonus payments depend on the terms of individual employment contracts.

	Total Remuneration	
Remuneration of Executive Officers (including Key Management Personnel Disclosed in Note 8.4)	**2019 $'000**	2018 $'000
Short term Benefits	364	346
Post-employment Benefits	33	32
Other long-term Benefits	9	9
Total Remuneration (i)	**406**	**387**
Total Number of Executives	3	3
Total Annualised Employee Equivalent (ii)	3	3

i The total number of executive officers includes persons who meet the definition of Key Management Personnel (KMP) of the Mansfield District Hospital under AASB 124 Related Party Disclosures and are also reported within Note 8.4 Relates Parties.

ii Annualised employee equivalent is based on working 38 ordinary hours per week over the reporting period.

NOTE 8.4: RELATED PARTIES

The hospital is a wholly owned and controlled entity of the State of Victoria. Related parties of the hospital include:

- All key management personnel (KMP) and their close family members;
- Cabinet ministers (where applicable) and their close family members;
- Jointly Controlled Operation – A member of the Hume Rural Health Alliance Joint Venture; and
- All hospitals and public sector entities that are controlled and consolidated into the State of Victoria financial statements.

KMPs are those people with the authority and responsibility for planning, directing and controlling the activities of the Mansfield District Hospital directly or indirectly.

The Board of Directors and the Executive Directors of the hospital are deemed to be KMPs.

Entity	KMPs	Position Title
Mansfield District Hospital	Mr P. Officer	Chair of the Board
Mansfield District Hospital	Mrs R. Adams	Board Member
Mansfield District Hospital	Mr M. Beattie	Board Member
Mansfield District Hospital	Mrs G. Belle	Board Member
Mansfield District Hospital	Mrs K Brkljacic	Board Member
Mansfield District Hospital	Assoc. Prof J. Freemantle	Board Member
Mansfield District Hospital	Dr. P. Dalgliesh	Board Member
Mansfield District Hospital	Ms. K Lockey	Board Member
Mansfield District Hospital	Ms. L Watters	Board Member
Mansfield District Hospital	Prof. B Happell	Board Member
Mansfield District Hospital	Mr. C Butler	Chief Executive Officer
Mansfield District Hospital	Ms. M Hood	Executive Director of Clinical Services
Mansfield District Hospital	Ms. M Green	Executive Director of Operations
Mansfield District Hospital	Ms. A Jewitt	Executive Director of Quality and Safety

The compensation detailed below is reported in $'000 and excludes the salaries and benefits the Portfolio Ministers receive. The Minister's remuneration and allowances is set by the Parliamentary Salaries and Superannuation Act 1968, and is reported within the Department of Parliamentary Services' Financial Report.

Compensation – KMPs	**2019 $'000**	2018 $'000
Short term Employee Benefits	586	531
Post-employment Benefits	50	48
Other Long-term Benefits	13	13
Total	**649**	**592**

KMPs are also reported in Note 8.2 Responsible Persons or Note 8.3 Remuneration of Executives.

Transactions with KMPs and Other Related Parties

Given the breadth and depth of State government activities, related parties transact with the Victorian public sector in a manner consistent with other members of the public e.g. stamp duty and other government fees and charges. Further employment of processes within the Victorian public sector occur on terms and conditions consistent with the *Public Administration Act 2004* and Codes of Conduct and Standards issued by the Victorian Public Sector Commission. Procurement processes occur on terms and conditions consistent with the Victorian Government Procurement Board requirements. Outside of normal citizen type transactions with the department, there were no related party transactions that involved key management personnel and their close family members. No provision has been required, nor any expense recognised, for impairment of receivables from related parties.

	2019 $'000	2018 $'000
Other Transactions of Responsible Persons and their Related Parties		
The result of the period includes aggregate amounts attributable to transactions with Responsible Persons and Responsible Persons Related Parties in respect of:		
Mrs G. Belle through involvement in the business Mansfield Produce Store on normal commercial terms and conditions	1	5
Mrs G. Belle through involvement in the business Delatite Hotel on normal commercial terms and conditions	10	5

Significant transactions with government-related entities

Mansfield District Hospital received funding from the Department of Health and Human Services of $9.2 million (2018: $8.6 million).

NOTE 8.5: REMUNERATION OF AUDITORS

	2019 $'000	2018 $'000
Victorian Auditor-General's Office		
Audit of financial statement	28	26
Crowe Horwath (Albury)		
Internal audit services	25	25
	53	51

NOTE 8.6: EX-GRATIA EXPENSES

There have been no ex-gratia expenses relating to the reporting date which require further disclosure.

NOTE 8.7: EVENTS OCCURRING AFTER THE BALANCE SHEET DATE

There have been no events subsequent to the reporting date which require further disclosure.

NOTE 8.8: JOINTLY CONTROLLED OPERATIONS

		Ownership Interest	
		2019	2018
Name of Entity	**Principal Activity**	**%**	%
Hume Rural Health Alliance	Information Systems	4.00	3.94

Mansfield District Hospital's interest in the above jointly controlled operations are detailed below.
The amounts are included in the consolidated financial statements under their respective categories:

	2019	2018
	$'000	$'000
Current Assets		
Cash and Cash Equivalents	272	217
Receivables	52	153
Other	10	5
Total Current Assets	334	375
Non-Current Assets		
Property, Plant and Equipment and Intangibles	67	74
Total Non-Current Assets	67	74
Total Assets	401	449
Current Liabilities		
Payables	145	197
Lease Liability	16	17
Total Current Liabilities	161	214
Non-Current Liabilities		
Lease Liability	13	17
Total Non-Current Liabilities	13	17
Total Liabilities	174	231
Net Assets	**227**	**218**
Equity		
Accumulated Surplus/(Deficit)	227	218
TOTAL EQUITY	**227**	**218**

Mansfield District Hospital's interest in revenues and expenses resulting from jointly controlled operations and assets is detailed below:

NOTE 8.8: JOINTLY CONTROLLED OPERATIONS (Continued)

	2019 $'000	2018 $'000
Revenues		
Operating Activities	220	190
Member Contributions	131	130
Non-Operating Activities	4	2
Capital Purpose Income	0	162
Total Revenue	355	484
Expenses		
Employee Benefits	70	50
Information Technology and Administrative Expenses	240	223
Capital Purpose Expenditure	2	74
Expenditure PAS – GVH / AWH / NHW	0	177
Depreciation and Amortisation	33	31
Finance Charges	1	1
Total Expenses	346	556
Net Result	9	(72)

Contingent Liabilities and Capital Commitments
There are no known contingent assets or liabilities for Hume Rural Health Alliance as at the date of this report.

NOTE 8.9: ECONOMIC DEPENDENCY

Mansfield District Hospital is dependent on the Department of Health and Human Services for the majority of its revenue used to operate the entity. At the date of this report, the Board of Directors has no reason to believe the Department will not continue to support Mansfield District Hospital.

NOTE 8.10: AASs ISSUED THAT ARE NOT YET EFFECTIVE

Certain new Australian accounting standards have been published that are not mandatory for the 30 June 2019 reporting period. DTF assesses the impact of all these new standards and advises the Health Service of their applicability and early adoption where applicable.

As at 30 June 2019, the following standards and interpretations had been issued by the AASB but were not yet effective. They become effective for the first financial statements for reporting periods commencing after the stated operative dates as detailed in the table below. Mansfield District Hospital has not and does not intend to adopt these standards early.

Topic	Key Requirements	Applicable for annual reporting periods beginning on	Impact on entity's financial statements
AASB 15 *Revenue from Contracts with Customers*	The core principle of AASB 15 requires an entity to recognise revenue when the entity satisfies a performance obligation by transferring a promised good or service to a customer. Note that amending standard AASB 2015-8 *Amendments to Australian Accounting Standards – Effective Date of AASB 15* has deferred the effective date of AASB 15 to annual reporting periods beginning on or after 1 January 2018, instead of 1 January 2017.	01 January 2019	The changes in revenue recognition requirements in AASB 15 may result in changes to the timing and amount of revenue recorded in the financial statements. The Standard will also require additional disclosures on service revenue and contract modifications. The changes will have minimal impact on Mansfield District Hospital in relation to revenue from goods and services provided, as goods and services are invoiced on completion of provision of the services to customers.
AASB 2016-7 *Amendments to Australian Accounting Standards – Deferral of AASB 15 for Not-for-Profit Entities*	This Standard defers the mandatory effective date of AASB 15 for not-for-profit entities from 1 January 2018 to 1 January 2019.	01 January 2019	This amending standard will defer the application period of AASB 15 for not-for-profit entities to the 2019-20 reporting period.
AASB 2016-8 *Amendments to Australian Accounting Standards – Australian Implementation Guidance for Not-for-Profit Entities*	AASB 2016-8 inserts Australian requirements and authoritative implementation guidance for not-for-profit-entities into AASB 9 and AASB 15. This Standard amends AASB 9 and AASB 15 to include requirements to assist not-for-profit entities in applying the respective standards to particular transactions and events.	01 January 2019	This standard clarifies the application of AASB 15 and AASB 9 in a not-for-profit context. The areas within these standards that are amended for not-for-profit application include: *AASB 9* • Statutory receivables are recognised and measured similarly to financial assets *AASB 15* • The "customer" does not need to be the recipient of goods and/or services; • The "contract" could include an arrangement entered into under the direction of another party; • Contracts are enforceable if they are enforceable by legal or "equivalent means"; • Contracts do not have to have commercial substance, only economic substance; and • Performance obligations need to be "sufficiently specific" to be able to apply AASB 15 to these transactions.

NOTE 8.10: AASs ISSUED THAT ARE NOT YET EFFECTIVE (Continued)

Topic	Key Requirements	Applicable for annual reporting periods beginning on	Impact on entity's financial statements
AASB 16 *Leases*	The key changes introduced by AASB 16 include the recognition of operating leases (which are currently not recognised) on balance sheet.	01 January 2019	The assessment has indicated that most operating leases, with the exception of short term and low value leases will come on to the balance sheet and will be recognised as right of use assets with a corresponding lease liability. In the operating statement, the operating lease expense will be replaced by depreciation expense of the asset and an interest charge. Mansfield District Hospital does not currently have any operating leases, however any future leases will be recognised on the balance sheet.
AASB 1058 *Income of Not-for-Profit Entities*	AASB 1058 standard will replace the majority of income recognition in relation to government grants and other types of contributions requirements relating to public sector not-for-profit entities, previously in AASB 1004 *Contributions*. The restructure of administrative arrangement will remain under AASB 1004 and will be restricted to government entities and contributions by owners in a public sector context, AASB 1058 establishes principles for transactions that are not within the scope of AASB 15, where the consideration to acquire an asset is significantly less than fair value to enable not-for-profit entities to further their objective.	01 January 2019	The current revenue recognition for grants is to recognise revenue up front upon receipt of the funds. This may change under AASB 1058, as capital grants for the construction of assets will need to be deferred. Income will be recognised over time, upon completion and satisfaction of performance obligations for assets being constructed, or income will be recognised at a point in time for acquisition of assets. The revenue recognition for operating grants will need to be analysed to establish whether the requirements under other applicable standards need to be considered for recognition of liabilities (which will have the effect of deferring the income associated with these grants). Only after that analysis would it be possible to conclude whether there are any changes to operating grants. The impact on current revenue recognition of the changes is the phasing and timing of revenue recorded in the profit and loss statement.
AASB 2018-7 Amendments to Australian Accounting Standards – Definition of Material	This Standard principally amends AASB 101 Presentation of Financial Statements and AASB 108 Accounting Policies, Changes in Accounting Estimates and Errors. The amendments refine and clarify the definition of material in AASB 101 and its application by improving the wording and aligning the definition across AASB Standards and other publications. The amendments also include some supporting requirements in AASB 101 in the definition to give it more prominence and clarify the explanation accompanying the definition of material.	01 January 2020	The standard is not expected to have a significant impact on the public sector.

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